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Thesis

CONCEPTUALIZATION OF AFRICAN PRIMAL HEALTH CARE IN MENTAL HEALTH

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DECLARATION

I Neo Evodia Nare, declare that this research study is my own original work. It is submitted in fulfilment of the degree of Masters of Science at North West University Mafikeng campus not to any other university.

This research study is part of Seboka NRF project

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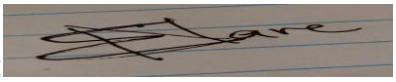
Signature: 

SEBOKA DECLARATION

SEBOKA

The potency of a lifelong initiative

This research project is a sub-project of the Seboka research Team. The African academic is firstly the child of mother Africa and secondly the creator of knowledge in the primary context of Africa and secondarily in the global sphere. The configuration of an African scholar's identity necessarily entails accepting a bundle of responsibilities shaped by mother Africa's potent imperatives. Etymologically defined, 'Seboka' denotes a 'group,' a 'team,' a 'community' and a phenomenal 'coming together' of sorts. The term of necessity subsumes one's ephemeral individuality under the value-generating ethos of 'communitarian' solidarity. A signifier of the shared benefits of synergy, the Seboka emblem - depicting a pride of lions on a mission under the supreme guidance of collective vision - is a celebration of the invaluable wealth of sharing and reciprocal engagement which lies at the heart of Africa's philosophy. As such, the Seboka concept was born out of respect for the imperatives of mother Africa, whose breast has availed the milk of human kindness moulding the African children into a team of valiant warriors in legitimate defence of their priceless heritage.

The Seboka logo summons to memory the telling axiom, 'A lion that goes on a hunt by itself, without co-existing in a pride, will always fail to catch even a limping deer.' In the same communitarian spirit, Seboka uses the claypot as a key emblem, symbolising sharing and communal solidarity. The Seboka team perceptively unpacks this definitive element of African life and essence, the profound *Ubuntu* philosophy, potently encapsulated in the dictum 'I am, because we are,' hence placing community and group care above the focus of the self. This Seboka team is a rich confluence of various tributaries, but the Community is their first consideration.

The hallmark of Seboka's invaluable research output has been the endeavour to strike signature partnerships with the community, the very custodians of the forests, mountains and rivers which are the abode of nature's healing essence and strength. Quite enlightening is the Khoi-chief's statement made recently in an open platform, *'The veld is our chemist'* (Kok V, 2013). The wisdom enshrined in this statement is a telling testimony of how conventional medical practice has always tapped into the resourcefulness of medicinal plants and other curative phenomena in Africa's rich forests. Notwithstanding the research on medicinal plants, the Seboka team predominantly re-engineer the broader practices of the African child

Seboka Greeting

ACKNOWLEDGMENTS

First and foremost I would like to humbly thank the heavenly Father, '*Senatla sa magodimo' le badimo booraNare le baba ba potapotileng'.* For the wisdom to carry on with this study even when the road seemed unclear and impossible. And also for the protection throughout this journey.

I dedicate this study to the following people, without them, this paper would not exist:

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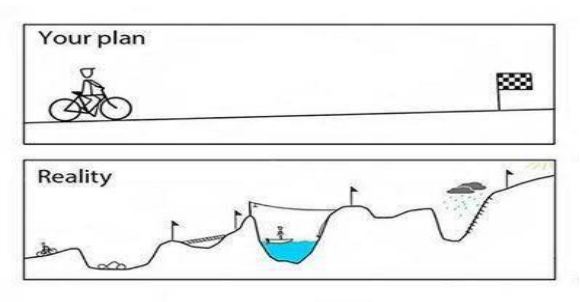
To everyone else I did not mention, who had direct or indirect impact on this study, I humble myself, *Asante Sana*.



LIST OF ABBREVIATIONS

APA- American Psychological Association

APHC- African Primal health care

PHC- Primary health care

WHO- World health Organization

ABSTRACT

Tittle: *Conceptualization of African primal health care in mental health*

To date African indigenous community make use of indigenous practices of promoting health and facilitating healing. The current primary health care system created a program called primary health re-engineering of which the health care providers do home visits and thus take the health services to the community. However, from time immemorial, the indigenous community had their own health practices (primal health practices) unique to their own community whereby the continent mother Africa provided plants for medicinal purposes as well as nutrition. What the current health care system is doing is just returning the practices back to the community.

The ultimate goal of this study is towards enhancing co-existence of both primal health care system and the western health care system with equal recognition and acknowledgement. Because indigenous knowledge system research is still at its infancy stage, conceptualization of common terms used is necessary to ensure consistency.

The study conceptualises African primal health care within mental health and make use of a qualitative method. Principle based concept analysis was used and five principles namely: philosophy, epistemology, pragmatic, linguistic and logical principles were used to conceptualise the concept African primal health care. The term ‘primal’ was coined during a colloquium in Lesotho by Dr Mbulawa and the Seboka team members. Seboka team members (indigenous knowledge system researchers) were selected as the study population as they are the most knowledgeable people regarding the concept African primal health care.

African primal health care was conceptualized as a communal based care, initiated by the community, for the community making use of natural resources such as medicinal plants to facilitate healing and promote wellbeing. African primal mental health case thus included holistic viewing of the community norms and values and involvement of the community in the healing process.

Keywords: Primal health care, mental health care, Primal mental health care, indigenous healer, conceptualization,

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SECTION 1

CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1. Overview

Mental health disorders affect more than 25% of all human beings at some point in their life (WHO, 2001:19). Shockingly an estimation of 450 million people worldwide has at least one mental disorder currently (McBain *et al*., 2012: 444). According to WHO (2001:19), 20% of patients who are examined at the primary health care services are diagnosed with one or more mental health disorders. Linking to the above-mentioned there is high incidence of mental health disorders (25% – 64%) in individuals treated for physical illnesses in the primary health care settings in the United States (Kneisl, 2013a:6). Subsequently, the researcher's experience as a professional nurse, the incidence of mental illness in South-Africa is similar.

Adding to the mentioned is the fact that neuropsychiatric disorders are a leading cause of disability worldwide and accounts for 37% of all loss of healthy life. (Wang, *et al*., 2007:841). Hence mental health, during 2000 accounted 12% of the global burden of disease Lund *et. al.,* (2007:352). Most facilities more often than not, cannot meet the needs of the mentally ill individual as personnel available are not trained or well equipped to work with mentally ill individuals and professionals who are trained and equipped are often unwilling to work with mentally ill individuals (Van Heerden *et al*. 2008:4; N'Gambi & Pienaar, 2013:94). Arguably, these factors make primal health the preferred health system used by indigenous people. Hence, it became unavoidable for the researcher to explore other existing support systems in health to support the mental health care challenges like the African Indigenous Health System.

1.2. Background

According to concise Oxford English dictionary (2008:1139), the word 'primal' originates from a Latin word *primalis* or *primus* in the 17th centuries which means *first.* Primal is then defined as 'relating to an early stage in evolutionary development' (Concise Oxford English dictionary, 2008:1139). Primal is also termed 'primordial', meaning 'original' (Freshwater & Maslin-Prothero, 2005:479). Taaka *et al.* (2013:128) cited Mosby's dictionary of medicine, nursing and health profession (2009) further said that primal is something that comes from the mother. The African community refersto their continent as mother Africa.Therefore, she (mother Africa) takes care of her African children by giving them medicinal plants and animals to heal (Taaka, *et al*., 2013:128). Health care refers to the organised medical care that is given to an individual or community (Concise Oxford English Dictionary, 2008:658). Bailliere (2009:69) further elaborated that with health care, there is continuous provision of welfare and protection, which leads to promoting well-being and preventing any disorders (including mental disorders).

Mbulawa (2013), on a Seboka capacity building workshop held in Tanzania, mentioned that primal health is a health care practice that is practiced locally with pre-existing knowledge by a specific indigenous community, and was developed through lived experience over a period of time by that specific indigenous community. In addition, Mbulawa (2013) said that primal health is 'local community knowledge'. African primal health care thus refers to indigenous health care that originated in Africa (Taaka, *et al*., 2013:128).

Considering the discourse regarding the concept primal or primordial healthcare, it is clear that they concur that it means first or original health care. Hence the researcher agrees that there was a health care delivery system in Africa before colonization, however this system has been marginalized after colonization and therefore was practiced either in secrecy or disregarded by the western education system. Contrary to expectations the primal health care system stood the test of time, because even currently most indigenous Africans make use of the African primal health care system. Therefore this research endeavours to conceptualize African primal health care within mental health.

Focusing on Mental Health Care, it is noted that problems are encountered when access to mental health care is needed in primary health care facilities (Kneisl, 2013a:6). According to Thom, (2004:33) and Ssesbunnya (2010:117), there is constant loss of experienced professionals, and there are few mental health professionals trained in the African continent (Atindanbila & Thompson, 2011:457). An average number of health and mental health professionals in all countries was found to be low and almost half of the countries (90% of African countries and all south east Asian countries) stated having less than one psychiatrist per 100 000 people (Jacob,*et al.,* 2007:1061). The ratio for indigenous practitioner per community is 1:200 as compared to 1:100,000 for western trained medical doctors and psychiatrists respectively (Atindanbila & Thompson, 2011:459). Psychiatrists are rare in low and middle income countries and are expected to assume multiple roles of diagnosing and treating patients, training staff members while managing the facility at the same time (McBain, *et al*., 2012:445).

Mental health care has been provided mostly in psychiatric hospitals and hardly in general hospitals or community settings (Van Heerden, *et al.,* 2008:4).Although there is a current move towards community-based care regardless of this, Valfre (2001:17) is concerned that most of the mental health care facilities are based on diagnosing and providing treatment. Noteworthy, the psychiatric hospitals are understaffed and overpopulated to such an extent that available staff on duty can only focus on performing what is considered essential nursing tasks such as giving of medication thus neglecting psychotherapies (Janse van Rensburg, 2010:385). In 2007, there were 101 295 number of registered Professional Nurses and 6 310 registered Psychologists in South Africa (HWSETA, 2008:11). This is in contrast with the 1978 Alma-Ata declaration which states that the country shall at local as well as referral levels rely on suitably trained health workers to respond to the expressed needs of the community. The same declaration states that the cultural aspects of the communities will be a priority in all spheres of health. Therefore, it is no surprise that the Alma-Ata declaration's standards were not reached in Africa (Alma-Ata, 1978:2).

Prior to the evolution of modern health medicine, African indigenous individuals made use of indigenous health care services.This included consultation/visits to the various indigenous practitioners (Gumede, 1990:45). The use of indigenous practitioners is a wide-spread practice in South Africa, (even in urban areas) especially for mental health related problems, where Africans prefer indigenous practitioners as opposed to western health care (Sorsdahl, *et al.,* 2010:284; Ovuga, *et al.,* 1999:276). WHO revealed that over 80% of the African community make use of the indigenous practitioners (Mzimkulu & Simbayi, 2006:417 cited from Mabunda, 2001; Bodibe, 1993; Freeman, 1992; Atindanbila & Thompson, 2011:458). At times, indigenous practitioners as well as medicinal plants are the main source and often the only source of health care to many people (WHO, 2013:16). Atindanbila and Thompson (2011:458) reportthat the participants in their study mentioned that western methods dealt mostly with temporary relief of symptoms, yet the underlying social as well as moral challenges still remained unresolved, and this might be influenced by the believe of the cause of mental illness (Ensink, & Robertson, 1999:24). Therefore, it is noteworthy to acknowledge that most countries practice their own form of indigenous healing firmly rooted in their culture and history (WHO, 2013:25).

African indigenous communities believe that ancestors are responsible for the well-being or ill health of an individual and his/her family.Thus,if one keeps the ancestors happy (performs rituals accordingly), the family will be protected from evil forces and harm (Pienaar & Manaka-Mkwanazi, 2004:132). However, ignoring the rituals may cause the ancestors to turn their back on an individual and thus no protection will be given putting that individual and his/her family in danger of psychosomatic and psychological illnesses (Pienaar & Manaka-Mkwanazi, 2004:132). In contrast, in the Western communities, illness tendsto be reduced to a particular disease, with the emphasis on the pathophysiology with the body part mostly given attention alone and not the individual as a whole (Kneisl, 2013b:168). In addition, Valfre (2001:34) says that modern health practices base their theory about illness strictly on western scientific findings and thus the management have to be scientifically proven; hence the discardment of treatment which cannot be scientifically proven according to the western society.

If cultural diversity is achieved at all levels of health care, it can influence the way in which the individual(s) of different culture's needs are being served (Anderson, *et al.,* 2003:73). Providing home and community-based health services and linking the services with the fixed primary health care facilities have proven to be critical to good health outcomes (Pillay & Barron, 2012:3). Making the community (especially family members) partners in care of mentally ill individual will reduce resistance to change (N'gambi & Pienaar, 2013: 99). The researcher is of the opinion that collaboration between consultants such as indigenous health practitioners and the western health care professionals in promoting mental health care will assist in early diagnosis and management of mental illness. Based on the background, the following problem statement was developed.

1.3. Literature review

A broader comparison between African and Western health care

Western methods deal mostly with temporary relief of symptoms yet the underlying social as well as moral challenges still remained unresolved and this might be influenced by the belief of the cause of mental illness (Atindanbila & Thompson, 2001:458; Ensink, & Robertson, 1999:24). Notably, African indigenous practitioners commonly locate the cause of psychological distress within the community and thus base the management within the community as well. (Mzimkulu & Simbaya, 2006: 418). Some of the features of mental illness common in African indigenous communities which were reported by indigenous practitioners includes bizarre content of speech, running away from home, talking alone or laughing inappropriately (when there is absolutely nothing funny around), undressing/removal of clothing items everywhere and poor personal hygiene (Ovuga, *et al*,. 1999:277). These features are commonly known to indigenous practitioners and the indigenous communities as 'a*mafufunyane' and mafonfonyane* in Xhosa and Setswana respectively (Mzimkulu & Simbaya, 2006: 418; Pienaar & Manaka-Mkwanazi, 2004:130).

Although most western trained health care providers assume that raw medicinal plants interferes with modern medicine, most medicinal plants used by indigenous practitioners have nutritional values and does not interfere with any function of the modern medicine (Taaka, *et al.,* 2013:128). Lengana, as one of the medicinal plants commonly used by indigenous practitioners, is high in protein and fat diet which is given to psychotic individual(s) to replace the energy used during episodes of psychosis (Taaka, *et al.,* 2013:127). Medicinal plants (in their raw nature) given to the African indigenous community by the indigenous practitioner is sacred(best for that specific disease and unique in every situation) as it is not just given to the individual needing them but rather communicated to the indigenous practitioner by the Ancestors (Taaka, *et al.,* 2013:126).

Modern medicine often make use of the same medicinal plant, synthesise it chemically then only take the active ingredient and make it in a form of tablet, capsule et cetera (Taaka, *et al.,* 2013:127). In addition, Pienaar and Manaka-Mkwanazi (2004:130) stated that some of the illnesses are believed by the African indigenous communities to be causes by germs, example of such illness is the influenza virus of which some African indigenous community often treat with vitamin rich medicinal plants like western communities would use vitamin enriched medication. Just like the modern medicine, the indigenous practitioner makes use of measurements when giving medicinal plants (Taaka, *et al.,* 2013:126). Instead of using milli-grams and milli-meters as a measuring guide, some of the measuring methods Africans make use of are the fingers and the palm of the hand of which the Africans believe is directly proportional to the body mass index (Taaka, *et al.,* 2013:126).

The exclusion on African and Indigenous health care by colonisation and religion

Prior to religion, mental health in Africa was considered to be supernatural and its treatment included using methods such as baths and venesection (Uys, 2014a:3).The Christians of African churches are developed in a way that resembles what is believed to be a typical African cultures because priests are a modern development of indigenous care systems and believe in supernatural powers thus uses faith healing for mental illness (Uys, 2014a:4). Ethnic groups in Africa were splinted at the end of the 19th centuries because of the agreement of colonial borders, indigenous people during that era were marginalised and seen as primitive (Ohenjo, Willis, Jackson, Nettleton, Good & Mugarura, 2006:1987). According to Marsella and Yamada (2000:13), supported by Kneisl, (2013b:168), acculturation is the process occurring when an individual or group from a specific cultural background is expected to change his own cultural believe and adapt another groups' culture.

The indigenous people are unable to maintain indigenous livelihoods and sustain indigenous culture and knowledge because their land and natural resources are lost (Ohenjo, Willis, Jackson, Nettleton, Good & Mugarura, 2006:1937). In the continent, indigenous people received little attention and are often referred to as the vulnerable group on the African continent and 'prejudicial attitudes to indigenous peoples' way of life in the national laws and government policies remain prevalent (Ohenjo, Willis, Jackson, Nettleton, Good & Mugarura, 2006:1937; 1938).The researcher is with the opinion that instead of making a person(s) to change his/her own culture to 'fit in' with the rest of the group, acknowledgement of his/her culture and allowing co-existence will prevent acculturation process.

Primary Mental health care currently

Mental health care users are missed because their first point of consultation is with the indigenous practitioner and they only consider the modern health care when the condition does not improve or worsens. Moreover, they still go back after discharge to consult with their indigenous practitioners as they need to be cleansed for the curse they believe was inflicted on them (Gumede, 1990:39).

Problems are encountered when access to mental health care is needed in primary health care facilities (Kneisl, 2013a:6). According to Thom (2004:33), there is constant loss of experienced professionals, and there are few mental health professionals trained in the continent (Atindanbila & Thompson, 2011:457). An average number of health and mental health professionals in all countries was found to be low and almost half of the countries (90% of African countries and all south east Asian countries) stated having less than one psychiatrist per 100 000 people (Jacob, *et al*, 2007:1061). The ratio for indigenous practitioner per community is 1:200 as compared to 1:100,000 and 1:1000, 000 for western trained medical doctors and psychiatrists respectively (Atindanbila & Thompson, 2001:459). Psychiatrists are rare in low and middle income countries and are expected to assume multiple roles of diagnosing and treating patients, training staff members while managing the facility at the same time (McBain *et al*., 2012: 445). In 2007, there were 101 295 number of registered Professional Nurses and 6 310 registered Psychologists in South Africa (HWSETA, 2008:11).

Western Health care refers to the organised medical care that is given to an individual or community (Concise Oxford English Dictionary, 2008:658). Bailliere (2009:69) further elaborated that with health care there is continuous provision of welfare and protection, which leads to promoting well-being and preventing any disorders including mental disorders. According to Seboka, African indigenous health means a healing process practiced within a specific community by means of divination. The healing process is different from community to community. As a result, the use of medicinal plants is also different, that is, the same plant can be used for different healing purposes by different communities.

Perusing these definitions, health for the researcher means a holistic healing approach within a community which focuses not only on the individual but includes the family and community at large. Within the healing process, divination and the use of medicinal plan are included and it must be noted that the healing process is highly spiritual and sacred.

Derived from the Latin word primalis or primus, *primal means first*, and it relates to an *early stage in revolutionary development* (Concise Oxford English Dictionary, 2008:1139). Primal, which also means primordial, refers to '*original'* (Freshwater & Maslin-Prothero, 2005:479). Prior to the evolution of modern health medicine, African indigenous individuals made use of indigenous health care services, this included consultation/visits to the various indigenous practitioners (Gumede, 1990:45).

According to the Seboka team, this health care including the researcher is known as primal health care. Hence primal health was the healing system used by indigenous Africans prior to the introduction of the modern health care system (Taaka, *et al.,* 2013:128). These authors further cited Mosby's dictionary of medicine, nursing and health profession (2009) indicated that primal is something that comes from the mother. The African community refers to their continent as mother Africa, therefore she (mother Africa) takes care of her African children by giving them medicinal plants and animals to heal (Taaka, *et al*., 2013:128). Therefore, indigenous Africans use the field as their pharmacy to obtain medicinal plan to facilitate the healing process. Conversely, healing within primal health care is holistic and intertwined and thus involves several processes such as spiritual divination (such as *ditaola*) and taking of medicinal plan remedies. Within primal health care, healing is unique and locally practiced from clan-to-clan and the knowledge is transferred from generation-to-generation through an initiation process called *ukuthwaza* (being trained to be a traditional healer) in Zulu.

As stated thus far, primal health care takes place within an indigenous community and start with the delivery of health care by fellow community members, the elders and indigenous health care providers.

1.4. Problem statement

African primal health care has been present and utilised from time immemorial and subsequently not getting the recognition and prominence it deserves as compared to western health care. Currently, the leading challenge is the recognition and respect for African Primal Health Care by predominantly western-educated health care providers. Also the fact that mental health care users are ridiculed by the western trainer health care practitioners when they prefer and choose to make use of indigenous health care services. Hence the researcher infers that if African Primal Health Care can be recognised equally alongside western health care, and both are allowed to co-exist, the burden of mental health care provision will be reduced notably. Therefore, the researcher endeavours to conceptualise African Primal Health Care in Mental Health to initiate the re-positioning Primal Health care among mental health care practitioners.

From the above problem statement, the following research questions were formulated:

1.5. Research questions

- What is the philosophical foundation for Primal Health Care in Africa?
- How can Primal health care be conceptualized in an African context?
- How can African Primal Health Care be re-positioned in Mental Health?

In order to assist in answering the above research questions, the aim of this research is as follows:

1.6. Aim and objectives of the study

Aim:

It is commonly believed from a western education system that the first contact should be with the nurse in the primary health care system.However, through experience as a clinical nurse in Primary Health Care (PHC), this is not the case.Therefore, the researcher would like to correct this misconception by conceptualising the real commencement of health seeking in an African indigenous community, namely; African Primal Health Care (APHC).

Therefore, the aim of the research is to formulate the concept African Primal Health Care (APHC) within a mental health care context. In order to achieve the main aim of this study, the following objectives were developed:

Objectives are to:

- Explore and the philosophical grounding of African Primal Health Care;
- Describe the epistemology of African Primal Health Care;
- Analyse, synthesise and crystallise the above-mentioned exploration and description in order to establish understanding within mental health and
- Conceptualise the concept, African Primal Health Care, within a mental health care context to enhance co-existence.

Subsequently to achieve the objectives of the study, the researcher has the following paradigmatic perspectives.

1.7. Paradigmatic perspective

Paradigm refers to ‘a world view underlying a theories and methodology of a scientific subject’ (Concise Oxford English Dictionary, 2008:1037). Freshwater and Maslin-Prothero, (2005:433) add that paradigms are used to describe a powerful experiences and those experiences can be used to inform future practice. It is of utmost importance for the researcher to explain beforehand the way he/she views the world including his/her beliefs and assumptions because the researcher’s world view has an influence on how she/he will conduct the research (Botma, *et al.,*

2010:186; Creswell, 2014:5). The researcher follows Mouton's view of the world which focuses on the philosophy; epistemology and pragmatic perspective (Mouton, 1996:7). This world view is elaborated as follows:

1.7.1. Philosophical underpinning

According to the Concise Oxford English dictionary, (2008:1077) philosophy is an attitude which guides individual behaviour. The researcher looked at behaviours related to health including mental health and primal health. Below is how the researcher views the person, family, and the community of which the researcher affirms. Philosophy is the use of rationale and argument in seeking truth, based on the belief system of a specific community (Concise Oxford Dictionary, 2008:1103). An example is that in mathematics, geometry, we accept an axiom that a straight line is 180 degrees. Mathematicians have to believein this widely accepted principle in order to resolve other geometrical problems (Pienaar, 2015a).

1.7.1.1. The person

A person is a holistic human being, consisting of body, mind, emotions and spirit, and is embedded in an indigenous social structure and culture: "*I am, because you are"* (Seboka team, 2013). In this research, the person is considered as a holistic being originating within an African indigenous society who believes in the indigenous ways of knowing and healing and lives in harmony with his/her community and the cosmos.

1.7.1.2. The family

The family, as viewed by the Seboka team (2013), is 'the property of being from the same kinship as another person'; this means any person within the same fore-parents as another person is regarded as family. For the purpose of the research, a family consists of any person within the community sharing the same ancestral clan.Hence the members of the family share the same indigenous healing practices and acts as care givers to restore the equilibrium and harmony.

1.7.1.3. The community

The researcher concurs with the Seboka team (2013) who views the community as person(s) within a group whom have interaction and relationship with each other, within their land and nature and the environment whereby communal beliefs and values are shared. In this research, the community is any person(s) sharing communal believes and values from the same clan. Hierarchy and chieftaincy within the community plays a vital role and *ubuntu* (*motho ke motho ka batho babangwe/ I am because you are, and you are because I am)* is a common lifestyle practiced by the community.

1.7.2. Epistemological underpinning

Epistemology is the knowledge about the researcher's reality (Brink, 2014:22). The researcher will be viewing knowledge from an African Indigenous knowledge system perspective. Indigenous knowledge system has been named differently by different researchers.Some researchers use the concept local knowledge, and others call it community knowledge while some uses the term 'traditional' knowledge (Seboka team, 2013). However,the most common definition for indigenous knowledge refersto 'unique knowledge, innovations and practices of local communities developed from experience within specific conditions gained over time, and adopted to local culture and environment of a particular geographical area' (Seboka team, 2013). Conversely, African indigenous knowledge system is a system of a set of knowledge, skills and practices existing and originated from Africans around specific conditions of inherent populations and communities (Seboka team, 2013). Therefore, in this research, the researcher's reality is anchored in African Indigenous from the knowledge system.

1.7.3. Pragmatic underpinning

Pragmatic underpinning entails everyday life and experiences where common sense, practical skills and morals are considered (Mouton, 1996:10). Pragmatic underpinning focuses on individual human beings, the collective society, social object and organizations (Mouton, 1996:10). Section 1.6.3.1 – 1.6.3.3 outline how the researcher views health, illness and healing. Therefore, the researcher supports Moutons views on praxis.

1.7.3.1. Health

The researcher looks at health from an African context; a healthy body alone is not regarded as good health (Seboka team, 2013; Le Grange, 2012:334). Good health rather requires harmony between the body, the mind, emotions and spirit of the human being as well as maintenance of cultural distinctiveness aiming to achieve ultimate worth by interacting with other human beings, nature and the cosmos (Seboka team, 2013; Le Grange, 2012:334). In order to become fully human, the person must not only take care of self and other fellow human beings but need also to take care of the cosmos (Le Grange, 2012:329). The researcher's definition of health is the ability to maintain harmony within the three spheres of the human being (namely; the body, mind, and spirit) in relation with the cosmos. As a result, the person is a holistic being and if one part is not in harmony with the cosmos health will not be obtained.

1.7.3.2. Illness

Illness refers to any disharmony occurring in a person interfering with the physical body, the mind, emotions, spirit as well as in the interaction and relationship with others, nature and the cosmos (Seboka team, 2013; Degonda & Scheidegger, 2009:1). Therefore, the person cannot be at harmony if he/she exploits, deceives or acts unjust to fellow human beings or nature/the universe (Le Grange, 2012:33). In this research, illness refers to disharmony due to "*boloi"* which the modern society refers to as witchcraft, but also due to angry ancestors where a common Setswana

sentiment is used "*badimo ba mphuraletse".* The disharmony needs not only be physical but can also be mental, spiritual as well as emotional.

1.7.3.3. Healing

Healing is a holistic practice, a combination of art and science to help an ill person to return to the state of harmony of mental, physical, spiritual, and emotional well-being in relation with the environment and the cosmos (Seboka team, 2013). In this research, healing is regarded as the restoration of harmony to maintain holism by means of a combination of divination, healing rituals as well as the use of various medicinal plants. Healing is a process that needs to be maintained throughout one's life and is communicated through the spirit usually by means of "*ditaola"* (bones). The healing is individualised and sacred thus two individuals with similar symptoms will be treated uniquely.

1.8. Theoretical perspective

1.8.1. Conceptual definitions

The conceptual definitions that are applicable in this study are person, family, community, health, illness, healing. These concepts were defined in the previous section (section 1.7):

1.8.1.1 Mental health care

Mental health care relates to the promotion of well-being by preventing mental disorders, and giving of treatment, rehabilitation and counselling to already mental health affected individuals (Uys, 2014b:17). For the purpose of this study, mental health care refers to the provision of health care, as an aim of promoting and achieve mental and spiritual well-being. According to Pienaar (2013:50) spiritual well-being is divided into subsystems of which their component includes broader belief, religion, motivation as well as meaning in life. Broader belief entails belief in God and as soon as these believe becomes an obsession then possible mental health challenges are considered (Pienaar, 2013:50).

1.8.1.2. Communal

The term ‘communal’ is derived from the latin word *communalis* which means *shared or done by all members of a community* and the sharing involves the sharing of work as well (Concise Oxford English dictionary, 2008:289). For the purpose of this study, communal refers to all members of the community sharing the same ancestral clan, beliefs and lifestyle practices, therefore the unity of the community.

1.8.1.3. Conceptualisation

Botma *et al.,* (2010:57) cited Babbie (2008*)* who defines conceptualisation as the mental process where concepts which are viewed as complicated and vague are made to be more precise and detailed. This mental process aims at grasping the specific meaning of the phenomena of interest, which in this study is Primal health care (Botma *et al.,* 2010:57).

1.8.1.4. African Primal health care

Please Refer to section 1 the first two paragraphs of 1.2 page 1

SECTION 1

CHAPTER 2: METHODOLOGY

2.1. Methodology

Figure 1 below illustrates the research methodology used in this study which will be elaborated further.

2.1.1. Schematic design of the research method

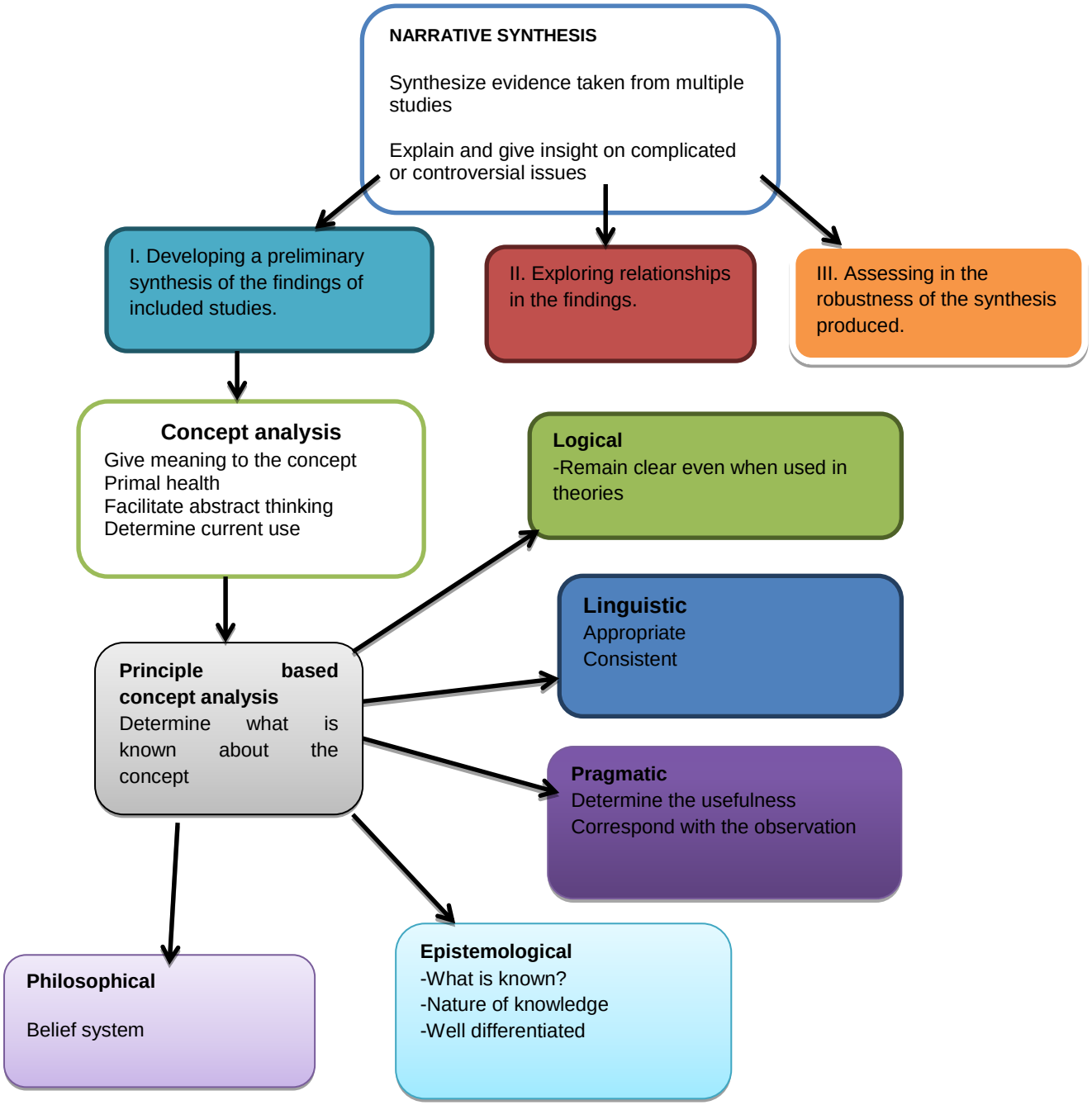

Figure 1 Conceptualization: African Primal Health Care

2.1.2. Research methodology

According to Brink, *et al*., (2014:113), qualitative research is a type of research design used to explore, describe and promote an in-depth understanding of human experience. Leedy and Ormrod (2010:135) further adds by saying that qualitative research aims at studying the phenomena occurring in a natural setting and study them in their complexity. Furthermore, data collection and data analysis are not seen as two separate processes in most qualitative studies but rather considered to be intertwined and ongoing (Nieuwenhuis, 2007:81).

As a research method, the researcher used narrative synthesis to assist with the conceptualisation of the concept primal health care in an African context. The research process in this study will be explored in 3 phases, whereby phase 1 will be to develop a preliminary synthesis using a concept analysis method, phase 2 will involve exploring relationships of the findings and the last phase (3) will be assessing the robustness of the synthesis produced. This process is elaborated further using a schematic presentation figure 1 above as well as an explanation of each stage.

2.1.2.1. Narrative synthesis

Narrative synthesis enables the readers to have insight on how explanations and empirical findings have linked and changed one another through time (Mays, *et al*., 2005:12). In addition, narrative synthesis is used as an aim to develop theoretical models, to identify, explain and give insight on complicated or controversial issues, to share information that can assist in improving practitioner's best practice and to bring new insight on emerging issues (Denyer & Tranfield, 2006:219). Primal health care is a controversial issue because it competes with primary health care and community health care.

Mays, *et al.* (2005:12) elucidate that narrative synthesis goes beyond just summarising the study findings, but rather attempts to bring new insights or knowledge and also be more systematic and transparent. Narrative synthesis refers to the research design process undertaken by the researcher to synthesise evidence taken from multiple studies (Harrison, *et al.* 2012:337; Denyer & Tranfield, 2006:219; Mays, *et al*., 2005:12). The researcher will focus on literature as well as Makgotla

(plural form of lekgotla) that the Seboka team interacted on in Lesotho and Tanzania respectively.

In an interview with the local village chief in North West Province, local village chief elaborated Lekgotla in an African indigenous content to be a gathering consisting mainly but not limited to males (usually residing in that particular village) and discussing any issues pertaining to the village (Motshegare, 2013). In addition, *lekgotla* is a Setswana word that when translated directly means council meeting (Pienaar, 2015b:63).

Lekgotla, was further explained by Pienaar (2015b:57 - 59) as a form of qualitative data gathering with the population of interest to the study the researcher is undertaking, and the researcher is allowed in the gathering as an observer. One person usually the chief chairs the discussion and every member in the discussion gives their opinion and expertise (Motshegare, 2013). According to Pienaar (2015b:66), the advantage of Lekgotla is that the researcher/observer is allowed to ask for clarity through the chair when anything is unclear.

Within the research context, Lekgotla occurs when the chief calls a community /public meeting to inform them about the research project after consenting to the project with the aim to get innovative and authentic outcome (Pienaar, 2015b:59). There is a specific process followed in lekgotla which starts with the chief being made aware of the matter to be discussedprivately and confidentially (Pienaar, 2015b:59). Once the chief is informed, he informs his advisors, (usually his paternal uncles or community elders) who are more knowledgeable on the matter discussed, and only then can the chief call the public meeting (Motshegare, 2013). The chief only give permission once he has had time to weigh risks and benefits of the research to the community during the pre-meeting with the researcher(s) assisted by council/advisor(s) (Pienaar, 2015b:59 - 65). The public meeting has no limit to the number regarding who should attend the meeting, that is, everybody in the community can attend (Motshegare, 2013).

For this study, a lekgotla was undertaken by using the Seboka team members consisting of beginners (honours and masters degree), novice researchers (PhD-candidates) as well as senior researchers. The colloquium was lead in the form of a lekgotla by two senior researchers, and occurred at the two Seboka capacity building conferences in Lesotho and Tanzania respectively. The discussion was based on the concept primal health care.

Referring back to narrative synthesis, Walker *et al.* (2010:744) suggest six steps of narrative synthesis while Mays *et al.* (2005:12) reduces the six steps to only three steps. The researcher will focused on only three steps which are common in both studies and the steps will be as follows:

- Developing a preliminary synthesis of the findings of included studies;
- Exploring relationships in the findings; and
- Assessing in the robustness of the synthesis produced.

I. Preliminary synthesis

For narrative synthesis, the researcher proposes to explore the concept with a process called concept analysis.

2.1.2.2. Concept analysis

The study focused on concept analysis. Clarifying of concepts makes it possible and visible to construct theory because concepts are used in theory development (Paley, 1996:572). In order to get clarity on a concept, the researcher needs to closely attend to the use of the word and by use it means the researcher looked at the dictionary definition and how such a word is used in a sentence for everyday situations (Fawcett, 2012:285; Risjord, 2009:685; Paley, 1996:573). Concept analysis determines the existing state of knowledge about primal health care so that the concept African Primal Health Care can derivate within a mental health care context.

The researcher followed the principle-based concept analysis method because it includes testing in multiple phases of conceptual definition within the socio-cultural context and other forms of data collection methods such as interviews, which are encouraged in order to identify diverse perspectives (Baisch, 2009:2465). The method was further elaborated in 1.8.2.2.1.

2.1.2.2.1. Principle based concept analysis

The method and design of principle–based concept analysis is organised around five principles which includes philosophical, epistemological, pragmatic, linguisticand logical principles (Russel, 2013:96; Kanaskie, 2012:241; Ruel & Motyka, 2009:385; Steis. 2009:1966; Bell, *et al.* 2007:571; Penrod & Hupcey, 2005:405). This method determines and evaluates what is known about the concept (Kanaskie, 2012:241; Ruel & Motyka, 2009:385; Penrod & Hupcey, 2005:405).

I. Philosophical principle

The principle–based concept analysis is organised around five principles of which one of the principles is philosophical principle which is discussed below. Withphilosophical principle, the researcher aims at giving more conceptual clarity (Mouton, 1996:9). Creswell (2014:6) and Botma, *et al.* (2010:187) arguethat meta-theoretical assumptions are often referred to as philosophical assumptions because they cannot be tested, (that is, it is what the researcher believes in). Meta-theoretical assumptions are what the researcher believes in with regards to the person as a human being, the community and the environment (Botma, *et al.* 2010:187).

II. Epistemological principle

Epistemological principle looks for what is known about the concept (Bell, *et al.* 2007:571). Because epistemology relates to the nature of knowledge, the researcher will need to have a mature concept (Russel, 2013:96; Ruel & Motyka, 2009:385; Penrod & Hupcey 2005:405). In addition, Penrod and Hupcey (2005:405) supported by Bell *et al. (*2007:571), Ruel and Motyka, (2009:385), Steis *et al. (*2009:1967), Kanaskie, (2012:242), Solli, *et al.* (2012:2804) and Russel (2013:96) mentioned that an epistemologically mature concept is well defined and well differentiated by definition from other concepts as well as positioned clearly in the literature. The researcher aims at defining primal health well and to its best description so that it is clearly differentiated from other concepts. The definition was derived from different experts in the Seboka team during lekgotla which was held in Tanzania and from existing literature.

III. Pragmatic principle

Pragmatic principle wasused to determine the usefulness of a concept within a discipline or practice (Kanaskie, 2012:243; Solli, *et al.* 2012:2807; Ruel & Motyka, 2009:385; Steis, *et al.* 2009:1967; Bell, *et al.* 2007:571; Penrod & Hupcey 2005:405;).The researcher considered pragmatic principles to look at the practices of primal health including the instruments used in primal health care (Mouton, 1996:10). Pragmatism's maturity was reached when the operationalization of the concept corresponds with the observations of practitioners within that discipline (Ruel & Motyka, 2009:385; Penrod & Hupcey 2005:405). Furthermore, Russel (2013:96) contend that 'pragmatic maturity should reflect recognition of the concept among members of the discipline'. It is also of importance for the author/researcher to identify the goal towards operationalization as well as measurement of the concept in research and practice as advised by Parse (1997:63).

The operational definition of primal health care for this study is health care prior to western health care, including health care transferred from one generation to another since time immemorial and if that operational concept up on collection and analysis of data begin to correspond with the data collected, the researcher can assume that primal health care has reached its maturity as a concept (Penrod & Hupcey 2005:405; Ruel & Motyka, 2009:385).

IV. Linguistic principle

When linguistic principle is mentioned, the science of language and human speech takes place, and in order for the principle to be considered matured, appropriateness and consistency of the use and meaning of the concept must occur across a variety of context (Russel, 2013:96; Kanaskie, 2012:244; Solli *et al.* 2012:2808; Ruel & Motyka, 2009:385; Steis *et al.* 2009:1968; Bell *et al.* 2007:571; Penrod & Hupcey 2005:406). The consistency and appropriateness of primal health care will be searched for when data analysis is done making use of the second step of phenomenological analysis which breaks the text/data collected into meaning units (Creswell & Plano Clark, 2011:136).

V. Logistic principle

Any concept that is analysed, including primal health care must remain clear even when used in theories (Russel, 2013:96; Kanaskie, 2012:244; Solli *et al.* 2012:2808; Ruel & Motyka, 2009:385; Steis *et al.* 2009:1968; Bell *et al.* 2007:571; Penrod & Hupcey 2005:406; Ruel & Motyka, 2009:385). Logical principle will occur when the concept assimilation with other related concepts has taken place. Logically matured concepts are concepts that have a clearly defined relationship to other concepts within a theory and this relationship does not violate attributes (Russel, 2013:96; Ruel & Motyka, 2009:385; Bell, *et al.,* 2007:571; Penrod & Hupcey, 2005:406).

2.1.2.3. Population and sampling

The population of this study wasthe Seboka team members who attended the capacity building in Lesotho, Tanzania, as well as those who could not. Seboka is a team of researchers who focuses on contemporary issues regarding indigenous knowledge system, which is in line with the phenomena of interest (Brink, *et al*., 2014:135). There is a beliefthat the larger the sample size the better the results.This holds true to some extend in quantitative study but is not applicable to qualitative studies because with qualitative designs, once a specific size is reached, the researcher will not improve the matter significantly by increasing the sample size (Brink, *et al*., 2014:135).The colloquium was open to all participants in a form of a debate until data saturation was reached. Botma and colleagues*, (*2010:202) assertthat in qualitative methods, the researcher does not know in advance how many participants are needed before hand.Therefore, continuous sampling is done until new data no longer appears, this process of re-sampling is called data saturation.For this research, data saturation was reached after only after the third colloquium held in Kimberly in the Northern Cape was conducted.

2.1.2.3.1. Non-probability sampling approach

A non-probability sampling is a type of sampling approach that may or may not represent the population accurately (Burns & Grove, 2009:353; Brink, *et al*., 2014:131). Non-probabilitysampling approachis usually more convenient if the researcher is unable to locate the entire population due to limited access (Brink, *et al.,* 2014:131). Not everyone in the non-probability sampling has a chance of being selected for the study (Burns & Grove, 2009:353).The researcher has to carefully selected data-sets of research colloquiums whichwere more relevant to the phenomena of the study within the Seboka (Brink *et. al*., 2014:132). The researcher used purposive sampling strategy as it was viewed as the most appropriate approach to assist in answering the research question.

Purposive sampling technique make use of an individual/focal person(s) who is believed to be more knowledgeable about the phenomena studied (Burns & Grove, 2009:355; Brink, *et. al.,* 2014:133). The Seboka team members are regarded as the most knowledgeable and appropriate sub-group about the African primal health concept as they engaged in discourses about the concept. Seboka team members discussed the concept primal health care during their capacity building workshop held in Lesotho and Tanzania (Seboka 2013; Taaka, *et al.,* 2013:128).

2.1.2.4. Data collection

In qualitative research, data collection is viewedas any form of information in the form of words (spoken or written), or various types of images including pictures, videos and or graphics (Lichtman, 2013:322). In this research data was collected using lekgotla which are discussed in the previous paragraphs. Conducting and documenting direct observations of the events and actions as they naturally occur is one of the approaches recommended by Yin, (2013:322 having cited the approach from Erickson, 2012:688; Maxwell, (2004, 2012); Miles and Huberman, (1994:132). The researcher is part of the Seboka team and that made active participation and access to the information discussed during the colloquia easy.

The researcher used lekgotla to collect data as described by Pienaar (2015). For full definition of lekgotla refer page 12. However, lekgotla in this research will be different in that the colloquia only included members who are more knowledgeable with regards to the indigenous knowledge system and primal health care. Lekgotla was led by two senior researchers who are regarded as knowledge holders instead of the chief. The colloquiawereopen to all participants in a form a debate until data saturation was reached. Botma and colleagues *(*2010:202) are of the opinion that in qualitative methods the researcher does not know in advance how many participants are needed before hand.Therefore, continuous sampling is done until new data no longer appears, this process of re-sampling is called data saturation. Therefore, data werecollected until saturation was reached (Brink, *et. al*., 2010:134).

The researcher used the audio as well as video recordings to collect data during the lekgotla; colloquia. The researcher took field notes as well as observing the whole process during lekgotla (Leedy & Ormrod, 2010:137; Bloor & Wood, 2006:28).

2.1.2.5. Data analysis

Analysis of data startedwhen the researcher transcribed the audio recordings, describing the setting, thereafter looked for themes within the raw data, and then compared the themes found (Bloor & Wood, 2006:28). In addition, Leedy and Ormrod (2010:138) cited Creswell (1998) and Stake (1995) who recommended fivesteps for data analysis which are as follows. The first step is where the researcher organises detail about the case, followed by categorising the data found (Leedy & Ormrod, 2010:138). The third step is then the interpretation of single instances; fourth step the researcher identifies patterns of data and lastly the synthesis and generalization of data (Leedy & Ormrod, 2010:138). The five steps are as follows (Leedy & Ormrod, 2010:138):

- Step 1: the researcher organises the facts found about the case in a logical manner.
- Step 2: finding of categories from the data to be arranged into themes.
- Step 3: data areanalysed for specific meanings that can relate to the case.
- Step 4: data that areinterpreted is examined for underlying themes and pattern.
- Step 5: conclusion about the data is made in a form of narrative story telling.

2.1.2.6. Crystallisation of data

When multiple methods of data collection and analysis are used to validate the results, the process is called crystallisation, and this process gives a complex and more deepened understanding of the phenomenon (Maree & Van der Westhuizen, 2007:40). Nieuwenhuis (2007:81) indicates that crystallisation aims at allowing the researcher to shift from viewing things in a fixed and rigid manner. Maree and Van der Westhuizen (2007:40) emphasise the point that it is of utmost importance for the researcher to attend to voices which differ from his/her own in order to learn more about multiple constructed realities. The different insights gained gives different perspectives which show the uniqueness of the realities and identify participants (Nieuwenhuis, 2007:81).

According to Maree and Van der Westhuizen (2007:39), in order to interpret validity and establish data trustworthiness, the researcher needs to consider triangulation which will be achieved by checking the extent to which conclusions based on quantitative sources are supported by a qualitative perspective and vice versa. This will be achieved by using different data sources of information (Creswell, 2014:191). Crystallisation of data in this research occurred when the researcher used the data collected from the three colloquia and the existing literature. To gain more insight from those sources, a more in-depth understanding of the concept African primal health care was established.

2.1.2.7. Conceptualisation

Botma, *et al.* (2010:57) cited Babbie (2008) who define conceptualisation as the mental process where concepts which are viewed as complicated and vague are made to be more precise and detailed. This mental process aims at grasping the specific meaning of the phenomena of interest, which in this study is primal health care (Botma, *et al.,* 2010:57). For this study, the process of concept analysis was used which was based on the five principles to make the concept African Primal health care more precise and detailed and thus conceptualising it.

2.2. Rigour

To ensure high quality research is important of all studies rigour should be maintained throughout the study. The term ‘trustworthiness’ in qualitative research is used to ensure rigour (high quality research) of the study and substitute terms such as validity and reliability in quantitative research (Polit & Beck, 2012:584; Creswell, 2014:191). To achieve trustworthiness of the qualitative data, the researcher used different data sources of information to ensure triangulation (Creswell, 2014:191).For this study, the participants were the main sources of information. The following steps were checked to ensure trustworthiness (Botma, *et al.* 2010:230):

- Data were documented accurately and completely;
- Correctness of the transcripts was checked by using the coding system; co-coding was done by a person with a masters in Psychiatric nursing and
- Triangulation of different sources of data and examining its evidence by checking the extent to which conclusions based on quantitative sources are supported by a qualitative perspective and vice versa (this will be achieved by using different data sources of information).

2.3. Ethical considerations

The research proposal was submitted to the Research Ethics Committee School of Nursing Science at North-West University for approval prior to the commencement of the study. As a Seboka team member, permission was also requested from the Seboka senior research collaborators to use dataset collected during the colloquiafrom the Lesotho and Tanzania workshops in their discourse.The researcher was a participant observer, a Seboka code of conduct was signed by researcher and each member of the team (refer to Appendix 1).

Theresearcher followed the five general ethical principles stipulated by American Psychological Association (ASA) (2010:3 – 4) and made them applicable to the study as elaborated below:

Table 1: Ethical considerations

General principle	Application
Beneficence and non-maleficence	A full explanation of the study was given to the participants, including the risks and benefit ratio.They were also informed that participation is voluntary and that they may withdraw from the study without any prejudice to them as members of the team, if they so wish.
Fidelity and responsibility	The researcher ensured that the participants of the colloquiacomprehended this information prior to participation (Botma, *et al*., 2010:11 – 12)
Integrity	With integrity, the researcher strives to promote accuracy, honesty as well as trustworthiness. Please refer to subsection 1.10 above for discussion on how rigour was maintained.
Justice	Participants were selected because they were considered to be most knowledgeable with the concept African Primal Health Care. Data wererecorded and safely stored in a steel cabinet at the school of nursing; a soft copy was also safely stored.
Respect for people's rights and dignity	The researcher also ensured that the rules of the colloquiaare obeyed by signing the Seboka code of conduct, and the participants' rights were protected which included the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment and the right to be protected from discomfort and harm (Botma, *et al.* 2010:11 – 12; Brink, *et al*., 2014: 32 – 40; Burns & Grove, 2005:195); hence only the name of the team was used anonymously.

2.4. Layout of the study

This report followed an article format as outlined in the North West University Manual for postgraduate studies, as well as the academic rules of the North West University.

Section one: Overview

This section served as an introductory angle to the study incorporating a general overview and the study backgrounds. Section one has two chapters. Enclosed in chapter one is the research problem, research questions, aims and objectives, paradigmatic perspectives and brief conceptual definitions. The research methodology is in chapter two and entails population and sampling, data collection and data analysis methods and literature review was also included.

Section two: Article

Section two has chapter three which is the article.

Title: conceptualization of primal health care in mental health care. The article reports on the empirical study and is written according to the author's guideline of Curationis (Journal of the Democratic Nursing Organisation of South Africa).

Section three: Conclusions, limitations and recommendations

In this section, the researcher discusses the conclusions in respect of the findings of the study which will be followed by the limitations and the recommendations of the study which are in chapter four.

2.5. Conclusion

Section one served as an introductory angle to the study incorporating a general overview and the study backgrounds. Enclosed in this section is the research problem, research questions, aims and objectives, paradigmatic perspectives and brief conceptual definitions. The research methodology entailing population and sampling, data collection and data analysis methods and literature review was also included. Section two gave the guidelines for authors according to Curationis (Journal of the Democratic Nursing Organisation of South Africa) and was followed by an article.

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SECTION 2

CHAPTER 3: ARTICLE

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J.K. (University of Pretoria) was the project leader, L.M.N. (University of KwaZulu-Natal) and A.B. (Stellenbosch University) were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. (Cape Peninsula University of Technology) made conceptual contributions and S.T. (University of Cape Town), U.V. (University of Cape Town) and C.D. (University of Cape Town) performed some of the experiments. S.M. (Cape Peninsula University of Technology) and V.C. (Cape Peninsula University of Technology) prepared the samples and calculations were performed by C.S.(Cape Peninsula University of Technology).

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Conceptualisation of African Primal Health Care within mental health care

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3.3. Conceptualisation of African Primal health care in mental health care

Keywords

Primal health care, mental health care, Primal mental health care, indigenous healer, conceptualization,

Abstract

Background: It is commonly believed from a western education system that the first contact should be with the nurse in the Primary Health Care (PHC) system. However, through experience as a clinical nurse in PHC, this is not the case. Therefore, the researcher would like to correct this misconception by conceptualising the correct beginning of health seeking behaviour in an indigenous African community, namely African Primal Health Care (APHC). This term 'primal' was first presented during a colloquium in Lesotho by Dr Mbulawa and the Seboka team members, however no formal conceptualization took place, except for an operational definition. Subsequently due to the scope of the study, the researcher narrowed the conceptualization to mental health, but this concept is applicable in the broader health context. The research was conducted for the purpose of contributing to the body of indigenous knowledge systems to advocate towards co-existence of primal health care and mental health care.

Aim:

The aim of the research is to formulate the APHC within a mental health care context. In order to achieve the main aim of this study, the following objectives were developed:

Explore the philosophical grounding of African Primal Health Care;

Describe the epistemology of African Primal Health Care;

Analyse, synthesize and crystallise the above-mentioned exploration in order to establish understanding within mental health; and

Conceptualise the concept African Primal Health Care within a mental health care context to enhance co-existence.

Design: the study followed narrative synthesis, concept analysis (qualitative design).

Settings: colloquia setting of capacity building workshops in Tanzania, Lesotho and Kimberley in the Northern Cape.

Participants: the participants involved in this study were the Seboka team members who were present at the capacity building workshops.

Methods: Lekgotla was used as a method of data collection and data were analysed using Leedy and Ormrod's five steps of data analysis.

Results: With the data collected, the researcher clinched that primal health care is a health care system that existed in Africa prior to the introduction of the current modern health care system. Moreover, it is based on the African belief system and cultural practices. The health care practices come from the community, to be used within the community and has to be authenticated by the community. Primal health care uses a holistic approach of healing whereby the family and community at large are involved in the healing process but also that healing does not focus on a specific part of the body but embrace the person as a whole (mind, body, spirit and cosmos).

Conclusions: Sequel to the aim of the study the researcher thus concludes that African Primal mental health care is an African original community-based health care system that is anchored within Ubuntu and the African indigenous belief system. Therefore, the given support system in the community is mobilised.

Linking with the support system, it makes use of the holistic approach to healing focusing not only on a certain aspect (presenting symptom) but includes the mind, body, spirit and cosmos. Healing within primal health care is facilitated through divination as well as the use of medicinal plants and the care provided is unique to each individual, family and community. The family and community play a huge role within the primal mental health care as they become the caretakers if they do not undergo the healing process themselves.

However, the healing process is not done by one person (even the indigenous practitioner) and this is derived from the Setswana Proverb that says: “Tlhogoyatsie e kgonaka go tswaraganelwa or sedikwakentshwapediga se thata” which emphasises cooperation and holism. Hence western and indigenous health can co-exist in the African primal mental health care system.

Introduction

Mental health disorders affect more than 25% of all human beings at some point in their life (WHO, 2001, cited by Wang et al. 2007). It is estimated that 450 million people worldwide have at least one mental disorder and 20% of all patients examined at the primary health care services are diagnosed with one or more mental health disorder (McBain, et al. 2012: 444). In addition, there is high incidence of mental health disorders (25% – 64%) in individuals treated for physical illnesses in the primary health care settings in the United States (Kneisl, 2013a:6). Subsequently, in researchers’ experience as a professional nurse, the incidence of mental illness in South-Africa is similar.

Adding to the mentioned factors, is the fact that neuropsychiatric disorders are a leading cause of disability worldwide and accounts for 37% of all loss of healthy life (Wang, et al., 2007:841). In 2000, mental health accounted for 12% of the global burden of disease (Lund, et al. 2007:352).

However, only a third of people suffering from mental disorders receive treatment for mental illness in high resourced countries and as little as 2% in some low- and middle income countries (Eaton, et al. 2011:1593). Even families with medical insurance find themselves responsible for the mental illness treatment costs because not all insurances cover mental illnesses (WHO, 2001:24). Less progress in response to mental, neurological as well as substance misuse disorders is observable, especially in the poorest countries regardless of the reportedly large treatment gap identification (Eaton, et al., 2011:1592).

Consequently, Kneisl (2013a:8 cited Prince et al. 2007) who argue that the burden of mental disorder is underestimated due to the fact that there is little appreciation of the connection between mental illness and other health conditions. Hence, unequal service delivery is given in the primary health care facilities with reproductive health care, child health care and physical health being given more attention in comparison with mental health care (Mangula & Pienaar, 2013:146). Therefore, it is common course that this practice in the western health system poses severe challenges for holistic care, including mental health challenges.

Background

It is noted that problems such as medication stock outs, staff shortages and long waiting time, to mention a few, are encountered when access to mental health care is needed in primary health care facilities (Kneisl, 2013a:6). According to Thom, (2004:33) and Ssesbunnya et al. (2010:117), there is constant loss of experienced professionals, and within the African continent, there are few trained mental health professionals (Atindanbila & Thompson, 2011:457). An average number of health and mental health professionals in all countries was found to be low and almost half of the countries (90% of African countries and all south east Asian countries) are reported as having less than one psychiatrist per 100 000 people (Jacob, et al. 2007:1061). The ratio for indigenous practitioner per community is 1:200 as compared to 1:100,000 for western trained medical doctors and psychiatrists respectively (Atindanbila & Thompson, 2011:459). Psychiatrists are rare in low and middle income countries and are expected to assume multiple roles of diagnosing and treating patients, training staff members while managing the facility at the same time (McBain, et al. 2012:445).

It is clear that indigenous health practitioners are more than western-trained practitioners and could alleviate the burden on the primary health care system if primal health care is understood and can formally co-exist with primary health care. Therefore this research is to conceptualize this concept from a foundational, philosophical context.

Research aim and objectives

Aim:

The aim of the research is to formulate the concept African Primal Health Care (APHC) within a mental health care context. In order to achieve the main aim of this study, the following objectives were developed:

Explore the philosophical grounding of African Primal Health Care;

Describe the epistemology of African Primal Health Care;

Analyse, synthesize and crystallise the above-mentioned exploration in order to establish understanding within mental health, and

Conceptualise the concept African Primal Health Care within a mental health care context to enhance co-existence.

Research design

According to Brink et al. (2014:113) qualitative research is a type of research design used to explore, describe and promote an in-depth understanding of human experience. As a research method, the researcher used narrative review and narrative synthesis to conceptualise the concept Primal health care in an African context. The research process in this study was explored in three phases, whereby Phase 1 was to develop a preliminary synthesis using a concept analysis method, Phase 2 involved exploring relationships of the findings and the last Phase (3) assessed the robustness of the synthesis produced. This process is elaborated further below using a schematic presentation as well as an explanation of each stage.

Schematic design of the research method

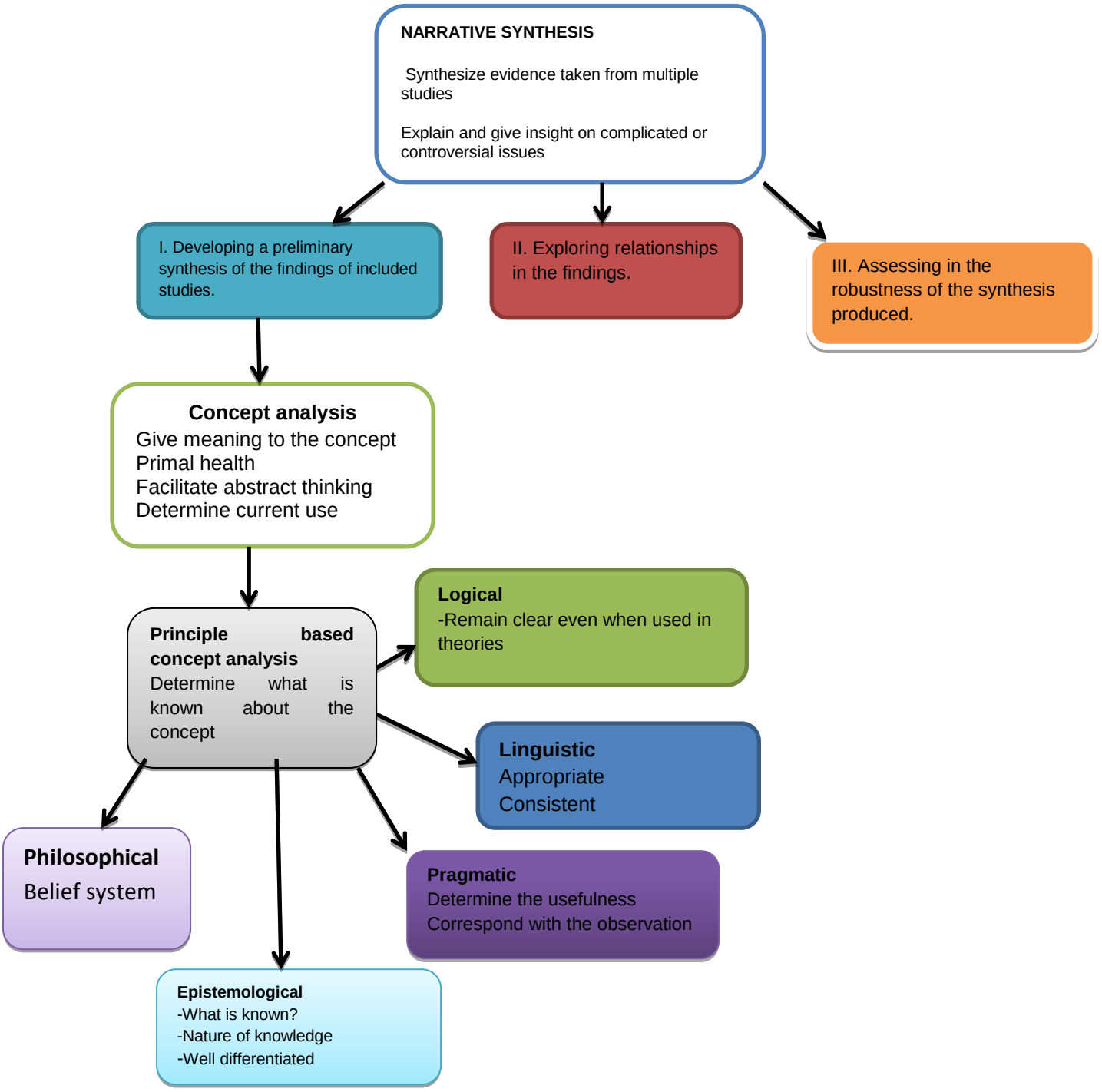

Figure 1 Conceptualization: African Primal Mental Health Care

Setting, Population and sampling

The population of this study was the Seboka team members. Seboka team is a community based indigenous research project under Indigenous Knowledge system (IKS), Project Number: NRF IKP 20701130000018563. The team consist of various African indigenous communities (KhoiSan, Basotho, Batswana, Shona); beginners researchers (honours and master's degree), novice researchers (PhD-candidates) as well as senior research collaborators across the Southern African countries. This team hold at least one capacity building workshop a year and the retrospective data of the workshops is available to all team members. This research made use of retrospective data collected in Lesotho, Tanzania and Kimberley in South Africa respectively. The discussion was based on the concept Primal health care and the colloquium was facilitated in the form of a lekgotla.

The team consisted of researchers who focused on contemporary issues regarding indigenous knowledge system, which is in line with the phenomena of interest. There is a belief that the larger the sample size the better the results. This holds true to some extent in quantitative study but is not applicable to qualitative studies because with qualitative designs, once a specific size is reached; the researcher will not improve the matter significantly by increasing the sample size (Brink, *et al*. 2014:135).

Non-probability sampling approach

A non-probability sampling is a type of sampling approach that may or may not represent the population accurately (Burns & Grove, 2009:353; Brink *et al*. 2014:131). In addition, non-probability sampling approach is usually more convenient for the researcher if he/she is unable to locate the entire population due to limited access (Brink, *et al*. 2014:131). The seboka team consist of researchers around the Southern African and during the colloquia not all members are able to attend due to administration challenges, therefore any team member who attended any of the three capacity building workshops took part in the research.

The researcher carefully selected datasets of research colloquia which are more relevant to the phenomena of the study within the Seboka (Brink, *et al*. 2014:132). The Seboka team members are regarded as the most knowledgeable sub-group about the concept African primal health concept, and the team discussed the concept primal health care during their capacity building workshop in Lesotho and Tanzania (Seboka 2013; Taaka, *et al.* 2013:128). The term 'primal' was coined during a colloquium in Lesotho by Dr Mbulawa and the Seboka team members.

Ethical considerations

The researcher followed the five general ethical principles stipulated by American Psychological Association (ASA) (2010:3 – 4) and made them applicable to the study as elaborated below:

Table 1: ethical considerations

General principle	Application
Beneficence and non-maleficence	A full explanation of the study was given to the participants, including the risks and benefit ratio, they were also informed that participation is voluntary and that they may withdraw from the study without any prejudice to them as members of the team, if they so wish.
Fidelity and responsibility	The researcher is part of the Seboka team as a beginner and thus had access to the information discussed during the Makgotla (singular- lekgotla). As part of the project regulation, all members sign a code of conduct upon joining the team. The code of conduct states the focus of the research project (community based/indigenous) as well as the role of each team member. The researcher ensured that the participants of the colloquia comprehended this information prior to participation (Botma et al. 2010:11 – 12)

Integrity	With integrity the researcher strived to promote accuracy, honesty as well as trustworthiness. • Data were documented accurately and completely; • Correctness of the transcripts was checked by using the coding system; co-coding was done by a person with a masters in Psychiatric nursing and • Triangulation of different sources of data and examining its evidence by checking the extent to which conclusions based on quantitative sources are supported by a qualitative perspective and vice versa (this will be achieved by using different data sources of information).
Justice	The term primal, which means original was coined during one of the Seboka colloquia by Dr Mbulawa and the seboka team members. Therefore participants were selected because they were considered to be most knowledgeable with the concept African Primal Health Care. Data were recorded and safely stored in a steel cabinet at the School of Nursing; a soft copy was also safely stored.
Respect for people's rights and dignity	The researcher also ensured that the rules of the colloquiums are obeyed by signing the Seboka code of conduct, and the participants' rights were protected which included the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment and the right to be protected from discomfort and harm (Botma, *et al.* 2010:11 – 12; Brink, *et al*. 2014: 32 – 40; Burns & Grove, 2009:195) Hence only the name of the team was used and no individual names are mentioned in the publishing of the research work.

Data collection and data analysis

Conducting and documenting direct observations of the events and actions as they naturally occur is one of the approaches recommended several researchers (Yin, 2013:322 having cited the approach from Erickson, 2012:688; Maxwell, 2004; 2012; Miles & Huberman, 1994:132).

The researcher used *Lekgotla* as a technique to collect data (Pienaar, 2015:59). Pienaar (2015:59 - 64) defines Lekgotla as a form of qualitative data gathering with the population of interest to the study the researcher is undertaking, and the researcher is part of the gathering as a participative observer. During lekgotla one person, usually the chief, chairs the discussion and every member in the discussion gives their opinion and expertise (Motshegare, 2013). *Lekgotla* in this research was different because the colloquia only included members who are more knowledgeable with regards to the indigenous knowledge system and primal health care concept and was led by two senior research collaborators instead of the chief. The researcher used audio and video recordings during Lekgotla to collect data; and field notes were also taken during the process (Leedy & Ormrod, 2010:137; Bloor & Wood, 2006:28).

Analysis of data started with the researcher transcribing data that included recordings (video and audio) and field notes, thereafter looked for themes within the raw data, then compared the themes found (Bloor & Wood, 2006:28). Leedy and Ormrod, (2010:138) cited Creswell (1998) and Stake (1995) who recommended five steps for data analysis which were applied in this research. The five steps are as follows (Leedy & Ormrod, 2010:138):

Step 1: the researcher organises the facts found about the case in a logical manner.

Step 2: finding of categories from the data to be arranged into themes.

Step 3: data is analysed for specific meanings that can relate to the case.

Step 4: data that is interpreted is examined for underlying themes and pattern.

Step 5: conclusion about the data is made in a form of narrative story telling.

Findings

Table 2: findings

From data analysed, the following eight attributes of primal health care evolved; primal health care (is):

Foundation in the African philosophy of Ubuntu and the belief system	**With Primal health care everyone is included in the healing process because an injury to one is an injury to all and with Ubuntu: *I am because you are and you are because I am*.**
Uses holistic approach, not compartmentalization	**The healing process is not separated into mental or physical health but rather intertwined in a holistic approach. the healing goes to an extend of not only including the ill individual but involving the family and at times the whole community,**
Primordial system	**Primal health care is the health care that originated in Africa and was practised in Africa prior to the colonisation era and introduction of modern health care system.**
Mobilizes support from within the family and community	**The family and community plays a big role in the healing process as the ill individual is nursed at home and not institutionalised.**
Practiced in the community	**Indigenous African communities believe in the bond between the living and the ancestors, and that indigenous practitioners have the calling/gift to connect the two. The connection process is done by the chosen community indigenous practitioners in the community for the community.**
Validated and confirmed by the community	**Before any use of a medicinal plan, the selected community members undergo an experimental journey whereby a sick animal eating that particular plant is observed and monitored for the healing process.**
Based on an acceptable process of learning, approved and accepted by community	**The indigenous student known as *mathwasana* undergo intense training before they can start to facilitate any healing process.Not everyone can become an indigenous practitioner as it is a calling.**
Uses natural resources available in the community	**African indigenous community make use of natural resources such as medicinal plants to facilitate healing.**
Supersedes primary health care and is cost effective	**Consultation of the indigenous practitioner is more affordable (payment is usually in kind and not in cash) and often the ill person only pays after he has recovered.**

Discussion

Developing a preliminary synthesis of the findings of included studies

Concept analysis

Within concept analysis, the researcher gave meaning to the concept “primal health”, facilitated abstract thinking and determined current use. The latter was done by first giving a theoretical definition of primal health care elaborating on the principle based concept analysis using the five attributes, philosophical, epistemological, pragmatic, linguistic and logical principle based concept analysis’

Theoretical definition of primal health care

Western Health care refers to the organised medical care that is given to an individual or community (Concise Oxford English Dictionary, 2008:658). Bailliere (2009:69) further elaborated that with health care there is continuous provision of welfare and protection, which leads to promoting well-being and preventing any disorders, including mental disorders.

According to Seboka, African Indigenous health means a healing process practiced within a specific community by means of divination. The healing process is different from community to community and thus the use of medicinal plants is also different (that is, the same plant can be used for different healing purposes by different communities).

Perusing these definitions, health for the researcher means a holistic healing approach within a community which focuses not only on the individual but includes the family and community at large. Within the healing process, divination and the use of medicinal plan are included and it must be noted that the healing process is highly spiritual and sacred.

Derived from the Latin word primalis or primus, primal means first, and it relates to an early stage in revolutionary development (Concise Oxford English Dictionary, 2008:1139). Primal, which is also means primordial, refers to ‘original’ (Freshwater & Maslin-Prothero, 2005:479).

Prior to the evolution of modern health medicine, African indigenous individuals made use of indigenous health care services, this included consultation/visits to the various indigenous practitioners (Gumede, 1990:45). This health care according to the Seboka team, including the researcher is known as Primal health care. Hence Primal health was therefore the healing system used by indigenous Africans prior to the introduction of the modern health care system (Taaka, et al. 2013:128). These authors further cited Mosby's dictionary of medicine, nursing and health profession (2009) and said that primal is something that comes from the mother. The African community refer to their continent as mother Africa. Therefore, she (mother Africa) takes care of her African children by giving them medicinal plants and animals to heal (ibid). As a result, indigenous Africans use the field as their pharmacy to obtain medicinal plan to facilitate the healing process. Conversely, healing within primal health care is holistic and intertwined and thus involves several processes such as spiritual divination (such as ditaola (bones) and taking of medicinal plan remedies. Within primal health care, healing is unique and locally practiced from clan-to-clan and the knowledge is transferred from generation to generation through an initiation process called ukuthwasa (training leading into being a traditional healer) in isiZulu.

As stated thus far, primal health care takes place within an indigenous community and start with the delivery of health care by fellow community members, the elders and indigenous health care providers.

Principle based concept analysis

Philosophical principle

The concept primal health care's philosophical principles are analysed based on the African context as the study is on an indigenous knowledge system. The concepts used to explain the African belief system are the person, his/her family and the community, and because the concept includes health care as an aspect, health, illness and healing are included as well. The person within the African context is a being not only consisting of flesh and blood but existing as a whole including his mind, body and soul. However, in Africa, no man exists in a vacuum. Therefore, the family members play a crucial role in each other's life. However, the family does not

only include the nuclear family members but involves uncles and aunties as well as cousins. The say: “Motho ke motho ka batho babangwe” (“I am because we are”). This is the anchor of African communities and the community considers themselves as one. When any member of the family or even community pass on, in Africa, it is believed that they cross over to the other world where they become the protectors and providers of spiritual guidance to the family and community as well. There is a special bond between the living and the deceased and dreams are used as a medium of communication between the two worlds.

With the special bond included, Africans make use of indigenous practitioners to facilitate the healing process where practices such as divination are highly practiced. Apart from dreams, the throwing and reading of bones (ditaola) are also used to spiritually deal with disharmony (illness) and thereafter facilitate healing.

Epistemological principle

If you kill a cat to see how it functions, the first thing you have is a non-working/dead cat.

The above statement referred to the holistic practice of the indigenous community within primal health care system. This finding is confirmed by the following direct quotation from a transcript:

The west take one thing and commercialise it and do not look at the holistic practice ... Like they are doing to our medicinal plants, they take one active ingredient and leave the rest out that is why their medication has such severe side effects.

Indigenous philosophers do not separate physical and mental illness, but rather believe that when an individual is ill, the illness affects the person as a whole (Van Dyk, 2005:195). African indigenous practitioners commonly locate the cause of psychological distress within the community and thus base the management within the community as well. (Mzimkulu & Simbayi 2006: 418). Some of the features of mental illness common in African indigenous communities which were reported by indigenous practitioners includes bizarre content of speech, running away from home, talking alone or laughing inappropriately (when there is absolutely nothing

funny around), undressing/removal of clothing items everywhere and poor personal hygiene (Ovuga, et. al,. 1999:277). These features are commonly known to indigenous healers and the indigenous communities as ‘amafufunyane’ and mafonfonyane in isiXhosa and Setswana respectively (Mzimkulu & Simbayi, 2006: 418; Pienaar & Manaka-Mkwanazi, 2004:130).

The statement below came up when one of the participants explained that as an indigenous knowledge decedent growing up in a primal health care setting, he was exposed to the practices and could give information on the practices without even practicing. Observation was the key most important aspect in primal health. Participants said:

During our training as indigenous practitioners, we look at a sick animal, we follow the animal, look at the type of plants it eats and look the rate of its recovery. We then take the samples of those plants and experiment with them first on ourselves, then others. Therefore, if there is such a thing as science, then indigenous knowledge is science as there is logic and it is systematic and there are experiments done.

Not everyone can become an indigenous practitioner as it requires an ancestral calling and skills training (Taaka, et al. 2013:126). Care within the primal health care is given at home or in the community and is given in a personalised manner (Valfre, 2013:12; 33). Prior to the evolution of modern health medicine, African indigenous individuals made use of indigenous health care services where the use of indigenous medicinal plants was high in practice (Gumede, 1990:45). Although most western trained health care providers assume that crude medicinal plants interfere with modern medicine, on the contrary, most medicinal plants used by indigenous practitioners have nutritional values and do not interfere with any function of the modern medicine (Taaka, et al. 2013:128). Lengana, as one of the medicinal plants commonly used by indigenous practitioners, is high in protein and fat diet which is given to psychotic individual(s) to replace the energy used during episodes of psychosis (Taaka, et al. 2013:127).

Just like the modern medicine, the indigenous practitioners make use of measurements when giving medicinal plants (Taaka et al. 2013:126). Instead of using milligrams and millimetres as a measuring guide, some of the measuring methods Africans make use of are the fingers and the palm of the hand of which the Africans believe is directly proportional to the body mass index (Taaka, et al. 2013:126).

Pragmatic principle

Most countries practice their own form of indigenous healing firmly rooted in their culture and history

During our training as indigenous practitioners, we look at a sick animal, we follow the animal, look at the type of plants it eats and look the rate of its recovery. We then take the samples of those plants and experiment with them first on ourselves, then others. Therefore, if there is such a thing as science, then indigenous knowledge is science as there is logic and it is systematic and there are experiments done.

The above statement was stated by one of the participants during data collection which explained how the indigenous communities determined the usefulness of medicinal plants in the absence of laboratory in vivo and in vitro studies.

Indigenous African society believes in the bond between the living and the ancestors, and that indigenous practitioners have the gift/ability to connect the individual consulting and his/her ancestors through the spirit (Degonda & Scheidegger, 2009:1; Marsella & Yamada, 2000:17; Gumede, 1990:10). The importance of the connection between the ancestor and the indigenous health user is based on the believe that ancestral spirits makes their presence to be felt by causing illnesses in the particular individual/family and also that disease is man made using the spirit as an agency of transmission (Gumede, 1990:19 & 41; Pienaar & Manaka-Mkwanazi, 2004:130).

In the African indigenous community, consulting an indigenous practitioner works both ways, either the sick but stable individual goes to the indigenous practitioners' practice room, usually a hut within the family yard. Sometimes the indigenous practitioner goes to the consultee because the condition of the consultee is critical and does not have enough money to hire transportation to the indigenous practitioner but other times because the ancestors instructed the indigenous practitioner to do so (Sorsdahl, et al. 2010:286; Pienaar & Manaka-Mkwanazi, 2004:135).

Mental health care users are missed because their first point of consultation is with the indigenous practitioner and they only consider the modern health care when the condition does not improve or worsens. In addition, they still go back after discharge to consult with their indigenous practitioners as they need to be cleansed for the curse they believe was inflicted on them (Gumede, 1990:39).

Linguistic principle

Ubuntu, I am because you are, and you are because I am and because you are and I am therefore we are... Ubuntu, the bed rock of indigenous knowledge.

The holism within the indigenous system is not only limited to the community but the cosmos at large. Then the researcher would further like to emphasise the two common terms within primal health care which are knowledge holders and knowledge carriers.

Knowledge holders can be taught the knowledge but knowledge carriers are born with the knowledge and it (knowledge) may or may not manifest itself.

The clay pot in an indigenous way or in the Sesotho way of doing things normally contains the African beer and in that clay pot, each and every one who is around shares the beer from the same clay pot.

The clay pot symbolises sharing ..... it is communal solidarity.

Logical principle

During consultation with the indigenous practitioner, detailed history taking, physical examination as well as divination are the common ways of finding a diagnosis (Atindanbila & Thompson, 2011:460; Ovuga, et al. 1999:277). The African indigenous healing system focuses mainly on the ‘whom’ than the ‘what’ way of healing, and the main question is whether it was the angry ancestors, evil spirit or bewitchment (Mzimkulu & Simbayi, 2006: 420).

Table 3: Exploring relationships in the findings

	Primal health care **Communal-based (family, community & indigenous clan (society)**	**Primary health care** **(Western- Community establishment-based)**	**Curative Hospital Based Health Care** **(Western- institution-based)**
Identification of the reason for consultation	During consultation with the indigenous practitioner, detailed exploration, physical examination as well as divination are the common ways of finding a diagnosis (Atindanbila & Thompson, 2011:460; Ovuga, et al. 1999:277). In most cases before an individual even considers to go consult an indigenous practitioner, he/she has already been visited by the ancestors to inform him/her about that individual. By the time that individual decide to consult the indigenous practitioner will already be awaiting him/her. A time frame is given and if that time passes without that person consulting, the indigenous practitioner will then visit the person at her/his home depending on the severity of the condition and the urgency thereof.	Valfre (2001:34) says that theory about illness strictly on scientific findings and thus the management have to be scientifically proven as well (tend to discard any management that cannot be scientifically prove). An individual has to have a bacterial, fungal or viral infection to seek consultation and symptoms must be present (tend to not treat asymptomatic individuals except in exceptional cases).	With western health care there are rules that determine the appropriateness of social and ethical behaviour and if an individual acts beyond what is considered legal behaviour, mental illness is then diagnosed (Kniesl, 2009:6; Sadock & Sadock, 2003:16). Only two psychiatric diagnoses were recorded by the health care professionals namely schizophrenia and epilepsy, which questions the knowledge and competence of the diagnosing individual (Modiba *et al*., 2001:192). The system prefers mostly referrals from primary health care with evidence that initial attempt was done to manage the illness prior to referral.
Disease management	Believes that illness is the results of bad spirit, thus consultation of indigenous practitioners are preferred to chase the spirit away and restore wellness through cleansing (Ssesbunnya *et al*. 2010:130; Kigozi, 2003:27; Atindanbila & Thompson, 2011:458; Marsella & Yamada, 2000:17; Gumede, 1990:10). The whole family and in some instances the community is given treatment. Instructions are given to the family members to facilitate	There are specialities within the health system e.g. psychiatry, oncology, medical, surgical etc., with the focus on the specific main complaint. Illness tends to be reduced to a particular disease, with the emphasis on the pathophysiology with the body mostly given attention alone and not the individual as a whole (Kneisl, 2013b:168). Medication given is for the management of the presenting symptoms.	The hospitals are understaffed and over populated in such a way that available staff on duty can only focus on performing what is considered essential nursing tasks such as giving of medication and neglecting psychotherapies (Janse van Rensburg, 2010:385).

	the healing process especially if the consultee is critically ill. Medicinal plants, hygiene and nutrition become the priorities followed by cleansing when the individual has recovered or is recovering. In some instances the indigenous practitioner will take the ill individual to his/her home where the indigenous practitioner's family and students *(mathwasana)* will care for the ill or rather the indigenous practitioner will move in to the ill person's home until recovery is obtained.		
Practices	There is a huge imbalance between urban and rural community health services in Africa and this lead to the health services remaining under developed and the well trained and specialized personnel relocating to the west (Atindanbila & Thompson, 2011:457; Kigozi, 2003:1 & 2). Decentralisation of mental health care users to the community is given priority, however the community is not approached to be made aware and also the liaison services are lacking (Kigozi, 2003:1). Sub-Saharan region seem to not be aware of the seriousness of mental health burden, as the epidemiological studies available are being limited. Indigenous health care is more affordable and accessible compared to the modern health care system (Degonda & Scheidegger, 2009:2; Atindanbila & Thompson, 2001:459). The cost within the primal health care system is cheaper and more flexible to accommodate the community, more often than not, the person only pays once full recovery is obtained	The use of the Band-Aid approach, treating only the presenting complaint (Valfre, 2001:12). make use of the same medicinal plant, synthesise it chemically then only take the active ingredient and make it in a form of tablet, capsule etc (Taaka *et al.* 2013:127).	According to Janse van Rensburg and Jassat, (2011: 25) supported by Janse van Rensburg, (2010:386). 17.3% of mental health care users in Helen Joseph Hospital had exceeded the expected period of admission that is. 25 days while 8% mental health users were re-admitted several times during a twelve month period. Kruger and Lewis, (2011:127) suggest that an increase in re-admission rate to secondary and tertiary psychiatric level might be mostly due to unsuitable community care facilities rather than the mental health user's condition. 'Readmissions also imply that inadequate follow-up of these users in community psychiatric services should be addressed' (Janse van Rensburg, 2010:388). Ramlall *et. al*., (2010:668) mentioned that the health care professionals could not comply with the mental health care Act as they had no

			sufficient beds and the staff was having challenges managing disruptive mental health care users. 69.4% did not have sufficient medical and nursing staff to provide the standard mental health required. This forced the hospital to rapidly and prematurely discharge mental health users who were not really due for discharge in hospitals and this lead to relapse (Deventer *et. al*., 2008:138, Van Heerden et. al, 2008:4) According to Thom, (2004:33) there is constant loss of experienced professionals, and there are few mental health professionals trained in the continent (Atindanbila& Thompson, 2011:457). Another constrain is that the facilities most of the time cannot meet the needs of the mentally ill individual as personnel available are not trained or well equipped to work with mentally ill individuals and more often professionals who are trained and equipped are unwilling to work with mentally ill individuals (Van Heerden*et. al,* 2008:4).

Robustness of the Primal Health synthesis

Robustness of the Primal Health synthesis

The primal health care practices come from the community, to be used within the community and has to be authenticated by the community. In addition, primal health care uses a holistic, communal approach of healing whereby the family and community at large are involved in the healing process but also that healing does not focus on a specific part of the body but embrace the person as a whole (mind, body, spirit and cosmos). Not everyone can become an indigenous practitioner as it requires an ancestral calling and skills training (Taaka, et al. 2013:126). An indigenous scholar must undergo an extensive process of learning to heal prior to joining the practitioner fraternity. Natural resources such as medicinal plants which are available within the community are used to facilitate healing. The services provided during primal health care consultation are cost effective and readily available (such as medicinal plants and the indigenous practitioner's home) and is more often than not the first contact before the modern health care services are considered as well as the last one to complete the healing process by means of a cleansing ceremony.

African Primal Health Care in mental health care

Lund, et al. (2007:352) highlighted that mental health accounted to 12% of the global burden of disease in the year 2000 Adding to this, Wang et al. (2007:841) revealed that the leading cause of disability worldwide is neuropsychiatric disorders which account for 37% of all loss of healthy life. However, it is still a concern to Eaton et al. (2011:1592) that less progress has been observed especially in poorest countries in response to mental, neurological as well as substance misuse disorders regardless of the large treatment gap identification. Only a third of people suffering from a mental disorders are treated in high resourced countries and as little as 2% in some low income as well as middle income countries are treated (Eaton et al., 2011:1593). Within primal mental health care, health care is practiced within the community for the community and it is founded within that community's indigenous practices using available and natural resources such as medicinal plants. The healing facilitated

within primal mental health is approved and accepted first by the community and will not only focus on the psychological aspects but will holistically focus on the body, mind spirit and the surroundings (family, community and ancestors). The family is involved in the healing process and can actively participate throughout the healing process.

According to Saxena et al. (2003) cited by Ramlall et al. (2010:667), 32% of the countries internationally did not have a specific mental health budget while 36% only used 1% of the allocated budget on mental health. In KwaZulu–Natal, only 0.03% is spent on mental health thus far. The issue of budget is a challenge in all level of health, and does not only affect primary health care services. Hospitals are also affected by this and the latter leads to an unsuccessful integration of mental health and primary health. With primal mental health care, the healing process facilitated and maintained is cost-effective as the resources used in healing are natural and easily obtainable within the community such as medicinal plants. Psychotherapy is provided by elders within the family with no limit to the number of sessions provided as in the case of 6 – 8 sessions prerequisite for modern psychotherapy and the sessions again will not be limited to time for example a maximum of 45 minutes to an hour per session, but will depend on the need assessed for psychotherapy. Even with limited time and number of contact sessions, time is still needed to build rapport before effective psychotherapy can prevail and progress be made. However, with primal mental health care, rapport is readily available as psychotherapy is not done by a stranger.

Therefore African Primal mental health care is in brief an African original communal-based health care system that is anchored within the African indigenous belief system and Ubuntu, where an injury to one becomes an injury to the entire community. Within mental health care, the healing process facilitated and maintained is holistic (not separated into mental or physical health but rather intertwined), communal and cost effective as the resources (human and other health) used in healing are natural and easily obtainable within the community.

Limitations of the study

The researcher has identified the following limitations with regards to the study:

Due to time constrains the researcher was unable to conduct a proper longitudinal study on concept formulation. However, the former will be bridged by further research on primal health care.

Recommendations

Recommendations for health practice

The researcher recommends that the western mental health care system and African Primal Health Care co-exist and be given equal recognition. Co-existence of mental health and primal health will assist in reducing the number of untreated mental health cases and hospital readmission. Kneisl (2013a:8 cited Prince et al. 2007) who contend that the burden of mental disorder is underestimated and this might be due to the fact that there is little appreciation of the connection between mental illness and other health conditions. Nevertheless, the latter will not be a challenge within primal health care as healing is facilitated holistically and not in speciality (compartment). Mental health care users are overlooked because their first point of consultation is with the indigenous practitioner and they only consider the modern health care when their condition does not improve or worsens. In addition, they still go back after discharge to consult with their indigenous practitioners as they need to be cleansed for the curse they believe was inflicted on them (Gumede, 1990:39).

Recommendations for teaching and learning

According to Antwi and Ziyati (1993:1), ‘Multi-culturalism is a way of creating an open atmosphere for the learning of different viewpoints and the acceptance of these kinds of differences’. Because the nurses are trained to work in an African indigenous community, the researcher recommend that a curriculum be developed that recognises African Primal health system on the same level as the western health care system. The following can also be done to facilitate co-existence:

Information sessions to illuminate the concept Primal Health Care in Mental Health

Portfolios, seminars, capacity building workshops and videos on African Primal Health Care to emphasise co-existence;

Strategies such as group discussions, role playing and case studies can be developed to strengthen co-existence; and

Students need to be made aware of African Primal health care and its attributes as well as how to merge it with the current modern health care system.

Recommendations for further research

Further proper longitudinal studies on concept formulation are recommended by the researcher. The research was also limited to mental health care. Therefore, the researcher recommends research into the different diverse health care systems.

Conclusion

The researcher conceptualized African Primal Mental Health Care in this research with the aim to advocate for the co-existence of primal health care and other western health care systems in Africa, with specific reference to mental health care. It is noted that African Primal Mental Health Care is a communal-based health care, therefore it is anchored in the Ubuntu philosophy. Communal is deeper than just the community, society or the public, it focuses on a mutual responsible and collective approach in delivering health care. Therefore the community is mutually responsible in the healing process, hence health care is provided in a family and communal context holistically to the health care user (Paul & Pienaar, 2013:40).

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SECTION 3

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1. Introduction

'We all think, and we all think we are correct; it is difficult for a man to begin to learn what he thinks he already knows'. A.J. Pienaar.

In this section, the researcher discusses the conclusions in respect of the findings of the study which will be followed by the limitations of the study and the recommendations of the study.The aim of the research was to formulate the concept African Primal Health Care (APHC) within a mental health care context. In order to achieve the main aim of this study, the following objectives were developed:

- Explore the philosophical grounding of African Primal Health Care;
- Describe the epistemology of African Primal Health Care;
- Analyse, synthesize and crystallize the above-mentioned exploration and description in order to establish understanding within mental health; and
- Conceptualise the concept African Primal Health Care within a mental health care context to enhance co-existence.

4.2. Realisation of data collection

As discussed in section one, data werecollected by means of Makgotla with regards to conceptualisation of primal health care in mental health. Moreover, the Lekgotla was not originally developed as a research data collection tool but was selected for this study because it is an exceptional tool to use for indigenous knowledge system studies. The advantage of a Lekgotla according to Pienaar (2015b:57) is that the researcher/observer is allowed to ask for clarity through the chair when anything is unclear. The data collected with the Lekgotla in this research was successful and produced rich and meaningful data. Data were collected from Seboka members who were present at the capacity building workshops.

Realization of the research objectives:

Objective One-

The study explored the philosophical groundings of African primal health in section 2 page 59. The objective was met because the researcher used African concepts to explain the African belief system of which then assisted in the analysis of the philosophical principles.

Objective two-

The epistemology of African primal health care was also described in section 2 page 59. The objective was met because the researcher was able to unpack African philosophy from different spheres including the healing process as well as knowledge generation process.

Objective three-

An understanding of the concept African primal health care within mental health care was established in section 2, page 68. The 3rd objective was also met because the researcher managed to elaborate on how African primal mental health will be practised.

Objective four-

In section 2 page 69 the concept African primal health care is conceptualised within mental health care in order to enhance co-existence.Theconcept African primal health care is conceptualised and the researcher advocated for co-existence of African primal health care and mental health care by assessing the robustness.

4.3. Conclusions

The researcher concludes that African primal mental health care is an African original holistic, communal-based health care system that is anchored within Ubuntu and the African indigenous belief system. Therefore, the given support system in the community is mobilised from inception to 'discharge'.

Linking with the support system, African primal mental health care makes use of holistic, communal approach to healing focusing not only on a certain aspect (presenting symptom) but includes the mind, body, spirit and cosmos. Healing within primal health care is facilitated through divination, ritualistic care (procedures in the western system) as well as the use of medicinal plants. The care provided is unique to each individual, family and community. The family and community play a huge role within the primal mental health care as they become the caregivers if they do notundergo the healing process themselves (Paul & Pienaar, 2013:40 - 41).

However, the healing process is not done by one person, but by the healing team (health practitioners, appointed indigenous nurse, family, community members) and this is derived Setswana proverb saying: "*Tlhogoyatsie e kgonaka go tswaraganelwa or sedikwa ke ntshwa pedi ga se thata," (an enemy attacked by two dogs is easily defeated)* which emphasises cooperation and holism. Hence the researcher is convinced through experience that western and indigenous health can co-exist in the African primal mental health care system.

4.4. Limitations

The researcher has identified the following limitations with regards to the study:

Due to the degree (masters), finances and time constrains, the researcher was unable to conduct a multi context study on concept formulation. The former will be bridged by further research.

4.5. Recommendations

Recommendations

Recommendations for health practice

The researcher recommends that the ***African Primal Health care and western mental health care system co-exist and be given equal recognition***. Co-existence of mental health and primal health will assist in reducing the number of untreated mental health cases and hospital readmission. Kneisl (2013a:8 cited Prince *et al.,* 2007) who contend that the burden of mental disorder is underestimated and this might be due to the fact that there is little appreciation of the connection between mental illness and other health conditions. Nevertheless, the later will not be a challenge within primal health care as healing is facilitated holistically and not in speciality (compartment). Mental health care users are missed because their first point of consultation is with the indigenous practitioner and they only consider the modern health care when their condition does not improve or worsens.In addition, they still go back after discharge to consult with their indigenous practitioners as they need to be cleansed for the curse they believe was inflicted on them (Gumede, 1990:39).

Recommendations for teaching and learning

According to Antwi and Ziyati (1993:1), ‘Multi-culturalism is a way of creating an open atmosphere for the learning of different viewpoints and the acceptance of these kinds of differences’. Because the nurses are trained to work in an African indigenous community, the researcher recommend that a curriculum be developed that recognises African Primal health systemon the same level as the western health care system. The following can also be done to facilitate co-existence:

- Information sessions to illuminate the concept Primal Health Care in Mental Health
- Portfolios, seminars, capacity building workshops and videos on African Primal Health Care to emphasise co-existence;
- Strategies such as group discussions, role playing and case studies can be developed to strengthen co-existence; and
- Students need to be made aware of African Primal health care and its attributes as well as how to merge it with the current modern health care system.

Recommendations for further research

Further multi context or grounded theory studies on concept formulation are recommended by the researcher. As the research was also limited to mental health care, thus the researcher recommends research into the different health care systems.

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ANNEXURE A:

THE GRIQUA ROYAL HOUSE
DIE GRIEKWA KONINGLIKE-HUIS

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MEMORANDUM OF UNDERSTANDING

This memorandum serves as an agreement reached between the Seboka Team under the leadership of Prof. Abel J. Pienaar and the Griqua Royal House. An appointed Seboka member will be expected to abide and respect the values and norms of the community while conducting research.

The following are the terms and conditions of agreement.

- The Seboka team is given the permission to conduct the research within the Griqua community, on a mutual capacity principle;
- The conducted research will be based on the Indigenous Knowledge Systems, of which the community will lead and guide the proceedings;
- The team (Seboka) will conduct the research using multiple research methodologies but the primary approach will be conducting "makgotla" with the assistance of a nominated member of the Griqua Royal House;
- The Seboka team will always respect the community and make sure that all the information is treated confidential;
- The research will be conducted by the appointed Seboka researcher, who will in turn sign the consent;
- Both parties also agree that the shared information remains the property of the Griqua Royal House unless otherwise stated;

This memorandum will be used as a global consent for conducting the research in the community. The participants' rights will also be taken into consideration and be respected while conducting the research. These rights are but not limited to the following:

A.M

ANNEXURE B:

"Ditau di senang seboka di siiwa ke none e tlhotsa"(A lion that goes on a hunt by itself, without co-existing in a pride, will always fail to catch even a limping deer)

CODE OF CONDUCT FOR SEBOKA MEMBERS

1. Purpose of the code of conduct

The code of conduct is a set of values, principles and practices that forms the foundation of the SEBOKA PROJECT. These principles depict the professional integrity, relationships with others, as well as the responsibility and accountability of Seboka Team Members towards each other and the communities they serve. The code of conduct is underpinned by the principle of UBUNTU.

The Code of Conduct governs how Seboka members behave in public or in private, or whenever the project will be judged by the actions of its members. The Seboka code of conduct is expected to be honored by everyone who represents the project officially or informally, claims affiliation with the project, or participates directly in the project.

2. Definitions

Professional Integrity- The Seboka member will act with care and diligence and make decisions that are honest, factual, fair, impartial and timely, after considering all relevant information (Harvard online dictionary, 2013) and (Online Dictionary, 2013).

Relationship with others- Means to treat other people with respect, courtesy and sensitivity, whilst recognizing their beliefs, interest, rights, safety and welfare.

Respect- is defined as consideration for self and for others. Respect includes consideration for other people's privacy, their physical space and belongings; as well as respect for different viewpoints, philosophies, physical ability, beliefs and personality (Balovich, 2006).

Accountability- This is to use information and resources in a responsible and accountable mannerthat ensures the efficient, effective and appropriate use (Online Dictionary, 2013).

Ubuntu-A quality that includes the essential human virtues; compassion and humanity (Online Dictionary, 2013).

3. Code of Conduct for Individuals:

The Seboka team expects that members will be truthful and forthright, and not engage in behavior that has serious ramifications for the welfare, academic well-being or professional obligations, of Seboka or others.

Be considerate

Decisions taken by any student or supervisor in Seboka might affect fellow members, therefore any decision taken within Seboka should be dealt with in consideration of how it

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would affect supervisors and students, and we should consider them when making decisions.

Be respectful

Disagreement is no excuse for acting in a disrespectful manner. Seboka members will work together to resolve conflict, act in good faith and do their best to act in an empathic fashion. Seboka members will not allow frustration to turn into a personal attack on any other team member.

Take responsibility for our words and our actions

To err is human; when we do, we take responsibility for our mistakes. If someone has been harmed or offended, we listen carefully and respectfully, and work to right the wrong.

Be collaborative

What Seboka will produce is a complex whole made of many parts, it is the sum of many dreams. Collaboration between members who each have their own goal and vision is essential; for the whole to be more than the sum of its parts, each Seboka member must make an effort to understand the whole.

Collaboration improves the quality of our work. Internally and externally, we celebrate good collaboration.

Value decisiveness, clarity and consensus

Disagreements are normal, but we do not allow them to persist and fester, resulting inleaving Seboka members uncertain of the agreed direction.

Seboka members will aim to resolve disagreements constructively. When they cannot, the matter the matter will be escalated to Seboka leaders to arbitrate and provide clarity and direction.

Ask for help when unsure

Nobody is expected to be perfect in this community. Asking questions early avoids many problems later, so questions are encouraged, though they may be directed to the appropriate forum. Those who are asked should be responsive and helpful.

Step down considerately

When somebody leaves or disengages from the Seboka project, it is expected that they do so in a way that minimizes disruption to the project.

Conflicts of interest

It is expected that Leaders and Students in Seboka be aware when they are conflicted due to employment or other projects they are involved in, and abstain or delegate decisions that

may be seen to be self-interested. It is expect that everyone who participates in the Seboka project does so with the goal of making life better for its users and the community, whom Seboka serves.

When in doubt, ask for a second opinion. Perceived conflicts of interest are important to address; as a leader.

Credit

Individual Seboka members do not seek the limelight, but celebrates team members for the work they do, with specific consideration of the community.

4. Code of Conduct for Leadership/supervisors and authority

Responsibility for the project starts with the project leader, who may delegate specific responsibilities to Seboka members. The Project leader may delegate decision making, governance and leadership from senior bodies to the most able and engaged candidates in Seboka.

A leader's foremost goal is the success of the team.

Leaders may be more visible than members of the team, leaders will use that visibility to highlight the great work of Seboka as a team.

Leaders must act to ensure that decisions are credible even if they must occasionally be unpopular, difficult or favourable to the interests of the Seboka project over an individual member.

Supervisors will guide students without prejudice, and will respect the input of the student.

Feedback from supervisors to students will be given within a timeframe agreed upon between student and supervisor.

Feedback given will be dealt with in a respectful manner to enhance the academic growth of the student, and to empower the student.

5. Conduct in service to communities

Seboka will foster collaboration between groups with very different needs, interests and skills.

Seboka will strive to ensure that diverse groups collaborate to mutual advantage and benefits.

Seboka will challenge prejudice that could jeopardise the participation of any person in the project or during the engagement between any members and the communities which Seboka serves.

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No Seboka member will engage in any activity which is not to the benefit of the communities which Seboka serves.

6. **Code of Academic conduct for Seboka members**

Absolute integrity is expected of every Seboka member in all academic undertakings.

Integrity entails a firm adherence to a set of values, and the values most essential to an academic community such as Seboka are grounded on the concept of honesty with respect to the intellectual efforts of oneself and others.

Academic integrity is expected not only in formal academic situations, but in all relationships and interactions connected to the educational process, including the use of Intellectual property and knowledge of the communities we serve.

All knowledge from the communities and fellow Seboka members should be acknowledged, and the Seboka members will truthfully report it at all times.

Intellectual property generated in Seboka remains the property of Seboka.

The Seboka logo and all trademarks associated with Seboka remains the property of Seboka, and may not be used without the permission of the Project leader and Senior project managers, without the necessary approval.

This Code is not exhaustive or complete. It is not a rulebook; it serves to distill our common understanding of a collaborative, shared environment and goals. The Seboka team expects it to be followed in spirit as much as in the letter.

I, NEO EVODIA NARE (Full Name and Surname) endeavours to uphold the above mentioned values, principles and practices as a member of the Seboka team.

Nare .....

Signature (Student)

Date: 15.04.2016

..... RR

Project leader/Supervisor

Date: 15 APRIL 2016

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- Autonomy and self-identification
- Privacy
- Confidentiality
- Justice
- Non-maleficence
- Voluntary participation
- Freedom of speech and movement as it will be an open forum

These conditions were discussed and agreed upon by the two parties (Community leader and Seboka Team leader). The terms and conditions discussed above are legal and bonding to the parties.

Signed at Mafikeng on 15 of April 2016

Seboka team leader : .....

Griqua Royal House : .....

Researcher : .....

Copies to: Griqua Royal House, Seboka office and researcher

His Majesty King Adam Kok V
His Excellency High Commissioner A M W Wesselsz

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ANNEXURE C: EDITING CERTIFICATE

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

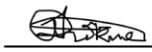
19 September 2016

TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Ms N.E. Nare's dissertation entitled: **"CONCEPTUALIZATION OF AFRICAN PRIMAL HEALTH CARE IN MENTAL HEALTH".**

I found the work easy and enjoyable to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors Guild.

Hereunder are my particulars:



Jack Chokwe (Mr)

Contact numbers: 072 214 5489

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Professional EDITORS Guild