A SHORT ETHNOPSYCHIATRIC STUDY
OF SWAZILAND

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Introduction

The Kingdom of Swaziland is one of the smallest countries in Africa – 6,700 square miles. It is located in Southern Africa and is completely land locked and surrounded by the Republic of South Africa and Mozambique and situated between the 26th and 27th southern parallels. It is one of the most recent independent African States (September 1968), is compact in shape, the distance from North to South being less than one hundred and twenty miles from East to West, less than ninety miles. It is divided into four well defined topographical regions extending in North South parallel belts.

1. The Highveld (western), rugged with an average elevation of 4,500 feet and climate humid and near temperate.
2. The Middleveld, consisting of rolling grassland with an average elevation of 2,500 feet and subtropical climate.
3. The Lowveld (eastern), mainly savannah country with an average elevation of 1,000 feet and climate almost tropical.
4. The Lubombo escarpment (eastern), with an elevation of 1,800 feet and climate similar to that of the Middleveld.

Many rivers, most arising in the Republic of South Africa, run through the country. It is thus well watered and fertile. The population is at present just under half million and

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The Swazi nation is a homogenous group of people who lost their multi-tribal affiliations many years ago and now identify themselves as one people owing allegiance only to their king, the Ngwenyama. There is no ethnic distinction. It enjoys a democratic form of government with a unique dual system and maintains a non-racial state without discrimination. This consists of a traditional tribal structure represented by the Swazi National Council the Libandla and the government of the kingdom of Swaziland, patterned on the Westminster model of party government. The government is headed by the king who is also country's spiritual leader. However, on the 12th of April, 1973, the king announced that he had suspended the constitution promulgated after the Independence of the country and decided that the government of the country would be conducted by the existing cabinet and the traditional Swazi National Council whose membership included all Swazi males or their representative. This latter government may be described as government by consultation and consent. This step was taken because the party system of government had introduced alien factors into the Swazi structure of government, factors which threatened the cohesiveness and the socio-cultural stance of the nation.

It is useful to note here that Leighton (1960) observed that social-cultural disintegration could lend to physical disorder and ultimately to psychiatric dysfunction. It also permits freedom of hostile and aggressive expression. It would appear that the king's action was an attempt to remove these disturbing elements from the society.

The economic activities of the country include the following:
1. Cattle ranching, meat canning and creamery.
2. Fruit, maize and rice production.
3. Seed cotton production and ginnery.
4. Tobacco farming.
5. Mining of asbestos, iron ore and coal.

6. Timber, veneered boards and other wood products such as wood pulp.

7. Sugar and sweets production.


There is a market contrast between the modern and the traditional sectors in the socio-economic development of the country, accounting for a great difference in the standard of living of the people and in their way of life. This is seen most strikingly in the field of agriculture. 85% of the total land area with 75% of the total population is based on traditional agriculture leaving only 15% or the arable land to sustain the whole or the modern agricultural economy. Most of the rural Swazis live under traditional conditions. Dwellings in the rural areas consist, for the most part, of wattle-and-daub structures or bee-hive buts and small family groups of six to eight persons, separated by distance of up to half a mile.

Historical perspective

During the latter part of the sixteen century the Swazis, together with other Bantu-speaking tribes moved southward from central Africa and settled in what is now Mozambique. The Swazis subsequently broke away from the main body round 1750. In the early 1800, they then moved northward to the area now known as Swaziland and succeeded in absorbing a number of the neighbouring clans.

First contact with the British was in 1840, after which event the first Europeans began to enter the country as hunters, farmers, traders and missionaries. British rule was introduced in 1877 for a short time but during this period some of the land belonging to the Swazis was annexed to the Transvaal and so separated some of the Swazis from their main group. The independence of the Swazis was granted by conventions signed by
the British in 1881 and 1884, but by 1895 the government of the country was taken over by the Republic of South Africa and in 1902, by the British after the Boer war. The country then continued as a colony or Britain until Independence was granted in 1968.

\( / p. 214 / \)

**Traditional disposition and practices**

The Bantu group of people including the Swazis hold the following beliefs which influence their attitude to mental health problems and colour their reaction to mental illness:

**GOD.**—He is the Supreme Being, Creator of all things and Controller of life eterna. He is the same as nature and every detail of nature is his handiwork. It is necessary therefore, to be thankful to Him for all the favours He has bestowed on the people. Hence the annual “Incwala”.

**SPIRITS.**—The Swazis believe that mentally ill patients are possessed by ‘bad spirits’ (Mandzawo). This belief is alleged to have arisen after the Swazi wars with the Zulus, when they were victorious and destroyed a large number of the enemy. On their return home, it was believed that they brought with them the “bad spirits” or the vanquished. Because of this mentally ill patients were shunned and deprived of their rightful place in the family hierarchy. If a mentally ill patient died at home, his bad spirit would transfer to another member of the family.

The rural Swazis believed that mental illness was infectious and behaved accordingly to the mentally deviant. This peculiar belief was sometimes seen in nurses. They would laugh at the mentally deviant, tease and taunt him to anger as a kind of defence mechanism, that by repudiation would stop the bad spirit from entering into them and thereby making them deviant also.

The Swazis believe also that an order of precedence exists in the spirit world, similar to what prevails on earth. These spirits could reveal themselves in a number of way i.e. dreams, through
clairvoyance, in a psychic trance, materialize in the form of visions and tokolosh (evil purpose dwarfs), and could send messages through diviners and magical bones. They maintain that a person is never alone, the invisible presence of his ancestors always remaining with him so that he fears no evil, not even death.

This is the fertile ground on which the traditional healers build their practice in mental deviancy.

**RELIGIOUS RITUALS.** – The Incwala. This originated in relation to agricultural activities owing to the effects of the elements which may cause failure of crops. In the kraals during spring and autumn, conversation would be centered mainly around this topic or crop failure and the weather.

The ceremony consists of two parts, the little and the great incwala. At both ceremonies the king is the central figure. The first fruit ceremony, the incwala, which takes place before the full moon in December, consists of the slaughter of a bull. Until this was done it was taboo to cut of the ripening crops. One should recall that by this time of the year, the reserves of the previous harvest were usually almost depleat and many of the rural people were by then on starvation ration. The main food of the Swazis is maize, cattle being accumulated as wealth. In some areas avitaminosis is prevalent and accounts for a high proportion of admissions to the mental hospital at Matsapha.

For the ceremony to be successful, blood should not be spilled and tempers should be kept subdued. After the king had been in confinement for about forty days, he is outdoored, offered a mixture of waters from the sea and rivers, collected by youths and other members of the nation in traditional manner, which he spits out. After all this has been done the ‘incwala’ gets into full swing and is graced by the dancing of beautifully attired maidens. Thanksgiving and offerings or appeasement are made to the shades of the spirits.

**WITCHCRAFT.** – A strong belief in witchcraft is prevalent.
In times of misfortune the Swazi would try to get to the bottom of it as if this could not happen through his own default. He would consult a diviner (*inyanga*) who would enlighten him on the cause of his misfortune by throwing his magical bones. After making the diagnosis, the enquirer would be advised to perform certain acts of appeasement, consult a witchdoctor to exorcise the black magic cast on him. At a price the doctor would supply him with protective medicine and talismans to render him immune to further attempts to harm him.

**BIRTHS.** – Every child born into a family must be purified to drive away bad spirits. This is done by letting it inhale fumes of a burning totem animal and drinking a special herbal potion of the family. If this was not done it was believed the child would grow up weak and feeble in body and mind. At the beginning of pregnancy, preparation are made for the performance of this ceremony. As there is no difficulty in securing the small totem animal, no anxiety results in connection with its performance.

**MARRIAGE.** – Before or soon after a woman gets married, the gall bladder of an animal would be placed on her head and a drop of the bile on her tongue to warn her of the bitterness she was likely to encounter in her new role. After the wedding, she was expected to move to the home of her in-laws and cook for them for a period. During this time she was not permitted to drink milk until she produced her first son. Her husband’s people were expected to offer five cows to her people, four for her father and one for her mother, “to dry her tears”. During her period of stay with her in-laws, she was relegated to a servile role for a varying number of years which may extend to ten years or more. This role is terminated only after she had a son and moved to her own home. She would then be in a position to expect similar obeisance from her daughter-in-law. Because of this practice young women are becoming more and more disinterested in marriage. However, in order to fulfil their role or womanhood, 80% of the young women prefer to have
illegal children than marry. This obnoxious marriage custom will slowly die out as members of the younger generation become more educated and sophisticated.

At the death of her husband, the widow would be confined to her home for thirty days. During this time she would wear her clothes inside out under her mourning dress. She would mourn for up to two years after which she would be free to encourage new friendships.

DEATH. – The Bantu culture, including the Swazis, believed there was no death. Dying merely released the spirit from the body, its temporary abode, to pass on to the next phase in life. This spirit than assumed the role or a watchful guide, a task-master and punisher of transgressors. The body also died at death and is buried with the possessions of the departed to prevent them falling into the hands of sorcerers /p. 217/ who would use them for malevolent purposes to the detriment of the mourning kinsmen. The departed spirit would then linger around its erstwhile home until a ceremony is performed to “send the spirit home” by the slaughter of cattle, prayers, incantations and offerings.

Some traditional ways of delivering medical Psychiatric services

Traditional healers are of three kinds:

1. Inganga: this is a diviner and a herbal doctor who in addition to other media, uses bones to arrive at a diagnosis of the cause of the disease and treats with herbs and barks of trees. He may also perform some operations.

2. Isangoma: the fortune teller.

3. Witchdoctor: the evil one who casts spells and brings on misfortune. These have been outlawed in Swaziland.
Traditional healers appear to take on all comers, medical, surgical and psychiatric uses.

In the treatment of diarrhoea, an *inyanga*, has been known to administer herbal potions as enema under pressure using goat’s horn as syringe, the medicine being blown up the rectum. When this treatment has been applied to infants it has been known to cause sloughing or the intestinal mucous membrane, perforation of the gut and death. Goat’s horn has also been used to enucleate tonsils with disastrous results at times.

Psychiatric cases are treated with herbal medicines for drinking and as enema. Attempts are made to limit treatment to disorders with cultural undertones. If there was no recovery after a period of time, the patient would be advised to go to the mental hospital at Matsapha. Two traditional healers informed me that they saw less than three psychiatric cases a year. As these men were described as practitioners of excellence, I regarded the Information as a gross understatement of the fact.

/p. 218/

Education

Education in Swaziland is under the control of the Ministry of Education which is responsible for primary, secondary, teacher, clerical and artisan training. In 1964, there were 374 schools with over 611,000 pupils. The Ministry as assisted by a non-racial central Educational Advisory Board and four similar District Committees.

PRIMARY. – The 342 primary schools, inclusively for Swazilanden and children of parents resident in Swaziland, are fairly well distributed over the high and middle velds, but are sparse in the low veld or the Lubombo district. There is a policy of integration of the races throughout the entire educational system. Instruction is in English.
SECONDARY. – There are eight secondary schools and these prepared students up to the G.C.E. “O” level, and one up to “A” level.

VOCATIONAL. – Teachers are trained for the higher and lower primary certificates. There are also available courses for clerical workers, domestic science teachers, agricultural extension officers and artisans.

The educational policy of Swaziland aims at the provision of a universal primary education, the diversification or secondary education to meet the demands of a changing society, the provision of better qualified teachers, building up of technical and vocational training and the granting of as many bursaries as possible for post secondary education. According to the 1966 census, the literacy rate for Swazis was 47% for males and 48,5% for females. Recently the primary school enrolment has risen i.e. between 1950 and 1968. Schools rose from 205 to 358 pupils from 14,300 to 62,100. Teachers rose during the period from 400 to 430. In 1968 out of 1,600 primary school teachers, 400 had no secondary education. Secondary schools rose from 10 to 51, pupils from 350 to 6,200 and teachers from 50 to 300. The rate of educational expansion is quite impressive.

In spite of this the training capacity is insufficient to meet the needs of the country in teachers and other categories of middle range manpower. The government’s policy now is to make primary education free and universal; secondary education free and available; professionals technicians and other cadres of artisans should be produced in sufficient numbers to meet the country’s needs.

Economic position and employment patterns

The economic structure of the country is dualistic – a well developed modern sector dominated by foreign enterprises, is heavily export orientated, accounting for 80% of the gross do-
mestic product. This sector provides employment for about 40% of the country’s labour force. Co-existing with this is the traditional subsistence economy or the rural areas which support some 70% of the population at extremely low levels of productivity. Recently, a small number of Swazi farmers have begun to participate in commercial farming. The country is as yet comparatively unindustrialized although bold steps are now being taken to change this. The rural Swazis however, depend on wage labour to earn money with which to purchase their non-agricultural needs.

The expansion of employment opportunities is a key problem facing the economy of the country. The rate of growth of the population is high and given as 3%. It is unlikely that the modern sector will be able to absorb the new entrants to the labour force. A large number of the young people reaching working age will have to find self employment in subsistence agriculture or allied rural activities. This is one of the factors that may lead to frustration, dissatisfaction with environmental conditions and consequently produce anxiety, a drift to indulgence in dagga (wee) and ultimately to mental deviancy. For the majority of the population, health, nutrition and housing standards are low. These often lend to loss or self respect and emasculation and provide fertile ground for mental disequilibrium. The general approach is an attempt to alleviate this situation seems to be to get the widespread participation of the Swazi people in the process of development in order to improve the general level of living and quality of life; secondly to achieve a greater measure of control over the economic affairs or the nation.

Existing medical and public health facilities

The health services of the country are maintained by the following:
In 1973 there were fifty-five doctors and four dentists. Of these twenty-two were in the service of the government and the rest were distributed as follows:

- Missions: 7
- Industry: 1
- Private: 1

Out of the total number of doctors, only seven were from Swaziland, the rest being foreign.

The total available beds during that year was 1,493, of which 200 were at the Matsapha mental hospital.

The following types of clinics operated at the Mbabane general hospital of 360 beds and 100 nurses:
- Maternal and child health (formerly), family planning.
- Paediatric.
- Orthopaedic.

Training facilities for medical and nursing personnel

The training of nurses is done at the Ainsworth Dickson Training College attached to the Raleigh Fitkin Memorial Hospital at Manzini. The course for general nursing covers a period of four years, plus an additional year for midwifery. At the end of training the successful candidates are issued with a board’s certificate. Nearly all the nurses in the country are Swazilanders and the school is capable of producing all the country’s needs. However, there was a very noticeable lack of psychiatrically trained nurses. None existed. Perhaps in the not too distant future the comprehensive type curriculum for nurse training
would be introduced at the training college so that all purpose nurses would be available to serve in the medical and health services in all its branches.

There are at present thirty medical students in training abroad. The first batch, a small number, are expected to start returning home by 1975. It will take a long time for the country to improve its number of Swazi doctors and achieve such excellence in expertise to be able to grapple effectively with its health problems. The country’s educational structure is now geared to meet this goal, so let us hope its achievement wont take too long.

Existing psychiatric services

The mental health services are a division of the health services but do not relate closely with any of the other departments of the Ministry of Health. This branch of the health services was described as ‘cut off’ from all other departments, relating directly only with headquarters as a result no interest is shown in mental health matters even when problems of this nature appear in other public health branches general hospital, maternal and child health clinic and at health centers. The first line of action is always to remove the patient to the mental hospital (at Matsapha) and get rid of the nuisance. This attitude further isolates the mental health division which should normally be a functioning integral part of the public health services as a whole. It would appear then that some positive action is called for to integrate the mental health services more properly in the general public health structure, if mentally ill patients are to receive enlightened and sympathetic handling at the peripheral supporting services.

STRUCTURE. – This branch of the health services appeared to revolve around and to be contained in the mental hospital at
Matsapha, the only hospital of this kind with a patient population of 200, plus or minus 20, at any one time, over the past four years.

The hospital consists of:
1. An administration building;
2. Two male wards with 128 beds with toilet;
3. Two female wards with 106 beds and ablution facilities;
4. An isolation ward with 12 beds and ablution facilities;
5. Two seclusion wards of 4 beds each, for males and females;
6. A well equipped kitchen;
7. Laundry;
8. And a well kept and productive vegetable farm.

Drugs are supplied from a central dispensary fortuitously situated near the hospital.

The hospital is located in an old army barracks which shares with a tuberculosis hospital, a criminal lunatic asylum, the central medical stores, the central dispensary and prison.

STAFF. — No definite staff requirements seemed to have been worked out as a guide to recruitment. At the time of my visit the following cadre of staff were at post:

• a part time medical officer who was in charge of the hospital in addition to his other duties at the prison;
• a nursing sister in charge during the absence of the doctor;
• six staff nurses (enrolled);
• two nursing auxiliaries i.e. part trained general nurses without midwifery certificate;
• thirty-two hospital attendants;
• three cooks;
• five gate keepers;
• one clerk.

FUNCTION. — The function of the hospital seemed to be:
• To protect and treat the mentally deviant in the community irrespective of their country of origin. Consequently the majority of the chronic patients over 60%, were nationals from neighbouring countries, who had been picked up by the police because they were round wondering at large and without visible means of support; also Swazi vagrant psychotics.

• To offer custodial segregation to patients who were outside the diagnosing acumen of the institution.

• To offer a limited programme for the rehabilitation of recovering patients.

/p. 223/

Rehabilitation procedures

The main approach in the rehabilitation of the mentally deviant patient was the very narrow view or secondary prevention, treating the patient when he is ill, securing a quick discharge from hospital and the start of the revolving door syndrome’ i.e. hospitalization, treatment, home, relapse, hospitalization again. There was an absence of the broader view of mental health rehabilitation with a joint hospital/community responsibility, that alone would spread an understanding of mental illness, help to meet the needs of discharge patients, train volunteers, make community leaders part of the hospital plans and programmes, and make available the best possible total treatment for hospitalized deviants.

All the rehabilitation procedures were therefore carried out at the Matsapha hospital will very little positive results despite the high percentage of discharges of admissions – 97.4% in 1970.

The following table gives an over all impression of the activity of the hospital with regards to admissions and discharges from 1969 to 1971.
45% of the population of Swaziland are fifteen years and under, 6% sixty years and over. From the table it will be seen that the most vulnerable age group to mental illness is between twenty and forty years and that morbidity showed a rise from 1969. This is the age group that maintains the country’s economic potential and contributes more than any other group, to the propagation of the nation. It is necessary therefore that this wastage should be reduced to a minimum. Some steps should be taken to control the known factors that lead to admissions such as excessive indulgence in alcohol, dagga (marijuana) and avitaminosis B, the factors that give rise to toxic psychotic reaction. Since the fifteen years and under group would be at risk in the future, suitable avenues should be created to marshal their energy and utilise their leisure in useful pursuits such as youth clubs or some paramilitary occupation.

Forensic attitudes

The legal procedures for admission to hospital are elaborate and cumbersome and are based on the mental disorder proclamation order, number 48 of 1963. It involves no less than nine forms and a final assent of the chief justice. Since access to traditional healers is informal and easy, the legal procedures should also be simplified to achieve a minimum of delay in seeking treatment in an informal manner. Other procedures for
compulsory detention should not be omitted for cases deserving this form of disposal. Discharges too should be as informal as possible. By these means it would soon be realized that mental disorder is not such a terrible disorder that calls for elaborate and rigid handling.

Methods

The only method existing in the country for the rehabilitation of mentally deviant patients in hospitalization and treatment.

The programme of the hospital consists of:
– diagnosis,
– treatment,
– discharge.

DIAGNOSIS. – This is difficult most of the time as the majority of the patients get to the hospital through nonmedical channels i.e. the district commissioner’s office and the police, without comprehensive medical histories. Owing to the absence of a psychiatrist and trained psychiatric nurses, a number of cases remain undiagnosed and so are deprived of appropriate treatment.

All new admissions are subjected to:
1. A blood test for Wasserman’s reaction. In 1972 there were fifteen positive cases.
2. Microscopical and chemical urine analysis, especially for bilharzia and B-coli infections, prevalent in the country.

A specimen or diagnosis made from 14 January to 31st August 1972 was as follows:

Schizophrenic reaction …………………. 82
Manic depressive reaction …………….. 12
Toxic psychotic reaction:
Alcohol and pellegra …………………. 16
Dagga (cannabis) ……………………. 21
Polio myelitis ………………………….. 1
Psychosis associated with epilepsy .......... 10

Organic reaction:
Senile dementia with myocardial degeneration  8
Cerebral syphilis ...................................... 6
Spastic .................................................. 3
Mental subnormality ................................ 1

TREATMENT. – This consists of the exhibition of psychotropic drugs of the phenothiazin group, namely: Chlorpromazine, Largactil, Trifluoperazine, Stelazine, Diazepam, Valium, Navane.

Anticonvulsants namely: Pbenobarbitone, Epanutin, Mysoline.

Miscellaneous, namely: Paraldehyde, Artane, Mist three fifteen.

All patients were first placed on Largactil for two weeks. If there was no improvement in the patient's condition the drug was then changed to another. Anticonvulsants were prescribed for the epilepsies and all the miscellaneous drugs were used as sedatives and hypnotics. In addition to these drugs some work therapy was given to the patients i.e. keeping the wards and premises clean, assisting in the kitchen, laundry and working on the hospital's farm. A few recovering patients did some occupational therapy, mainly women engaged in stringing beads in intricate patterns and making rugs from cloth scraps.

In addition to these measures a team of mental health workers visit the country in the 'Harry's Angel's' project of flying medical services from the Republic of South Africa a contribution by Harry Oppenheimer, the diamond magnate. Psychiatrists from the Tara Psychiatric Hospital from Johannesburg usually give this aid but then only in cases of forensic psychiatry.

DISCHARGE. – Out patient treatment of discharged patients at the Mbabane general hospital and at the mental hospital itself at Matsapha was once tried and yielded good results. This practice would be useful and serviceable if reintroduced. It should also be introduced in other hospitals such as at Pigg's Peak and Hlatiku, areas where toxic psychotic reaction prevail owing to the abundance of marijuana. There is at present no
follow up programme for the surveillance of discharged patients. The relapse rate is therefore very high and makes nonsense of the high percentage of discharges of admissions. Traditional and faith healers seem to hold the final pronouncement of cure or mental illness. In the rural areas, after improvement has been achieved by hospital treatment, these healers must give a kind of final absolution for the treatment to be complete, of course at a price.

Conclusion

Swaziland is a country of magnificent scenery, rugged in parts and rolling grassland in others. Its people are friendly and unhurried. The towns are small, clean and widely separated. It has a fast growing tourist industry. It was stimulating to find that the now ubiquitous western youth decadence present almost throughout the world has not yet permeated into this beautiful country where values of decent behaviour and respect for social norms still prevail. But alas, owing to /p. 227/ the osmotic tendency of permeation of ideas and trends from outside any country, one wonders how long Swaziland would succeed in blocking this invasion and with what resources she would hope to do so.

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RESUME:
UNE BREVE ETUDE ETHNOPSYCHIATRIQUE
DU SWAZILAND

L'auteur, – consultant de l'OMS pour la psychiatrie auprès du gouvernement du Swaziland en ce qui concerne les services de Santé mentale – propose une étude ethnopsychiatrique du pays tenant compte des paramètres suivants : les données géographiques, la position socio-économique du pays, son équipement éducatif, agricole, médical. Ces paramètres ont été étudiés du point de vue de l'observation psychiatrique. La pertinence de ces facteurs a été soumise à une analyse critique en inducteur de déviances mentales. Les plans gouvernementaux d’amélioration et d'extension de tous ces services pour le mieux être ont été décrits.

Quelques recommandations sont enfin proposées pour l'extension des mesures de santé mentale.

Mots clés : • Étude ethnopsychiatrique • Swaziland • l'Hôpital psychiatrique de Matsapha • Mental disorder proclamation order (n°48, 1963)

ABSTRACTS:

This is an ethnopsychiatric study of Swaziland, in which various parameters comprising the geography of the country, its socioeconomic position, educational, agricultural and medical services have been inquired into from the vantage point of psychiatric observation. The relevance of these factors in their traditional cultural setting, as conducers to mental deviancy, has been subjected to a critical analysis. The government’s plans for improvement and expansion of all facilities for better all round health has been described.

Finally, some recommendations on mental health extension have been advanced.

Key words: • Ethnopsychiatric study • Swaziland • Matsapha mental hospital • Mental disorder proclamation order (n°48 of 1963) •