An investigation of the acquisition, transfer and preservation of Indigenous Knowledge by traditional healers in Chibombo District of Zambia

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Abstract*: This study aimed at investigating the acquisition, transfer and preservation of Indigenous Knowledge by traditional healers in Chibombo District. The objectives of the study were to explore how traditional healers acquired Indigenous Medical Knowledge, identify the methods used during IMK transfer, identify the methods which were used by traditional healers to preserve IMK and to investigate the challenges which were associated with acquisition, transfer and preservation of medical knowledge. Using qualitative research method and snowball sampling, primary data were collected from 29 traditional healers and 5 key informants through face-to-face interviews. Findings revealed that traditional healers acquired knowledge of healing through training and ancestral calling. The study also established that the majority of trained healers were females as they were much more willing to be trained than males. Findings on IK transfer revealed that majority of traditional healers transferred IK on healing through demonstration and observation. Findings on knowledge preservation showed that majority of traditional healers were training their family and other interested individuals. Results on challenges during acquisition, transfer and preservation of IK revealed that would-be healers experienced sickness, difficulties in mastering what was demonstrated and observed, segregation from their known communities and panicking when patients showed no signs of recovering after administering the herbs to them. The need for community leaders in Chibombo district to consider educating the local youths during ceremonial gatherings on the need to acquire and preserve indigenous practices was recommended. This was seen as a way through which unwillingness to learn and share would be reduced. Secondly, it was recommended that collaborative efforts between community leaders and traditional healers to document most of the indigenous medicine and the ailments they healed be strengthened. This was seen as a way through which difficulties in mastering and panicking among the would-be healers reduce.

I. INTRODUCTION

African communities in rural setup have over the years relied on Indigenous Knowledge on climate, agriculture, medicine, health as well as education in the nonexistence of conventional knowledge generated through scientific research or statistical information. However, the current society has not appreciated the use of Indigenous Knowledge (IK) and others have associated its usage with witchcraft or black magic (Lumpa, 2017). This knowledge is passed on by word of mouth and cultural rituals from generation to generation and it is also known as local knowledge, folk knowledge, people's knowledge, traditional wisdom, or traditional science.

Emerging from IK was the establishment of traditional medicine which is cultural-based and existed in every society and it was the only medical institution which was available before colonial contact. However, colonisation of Northern Rhodesia by Britain necessitated a dead end to the use of traditional medicine as modern medicine was introduced. The genesis of modern medicine was followed by a fight to eradicate traditional medicine (Mulungushi Report, 1977) as cited in (Kanenga, 2013).

In the 19th Century when Zambia was still called Northern Rhodesia under the British colonisers, an Act was passed and under this Act, a campaign to eradicate traditional medicine was launched. The campaign aimed at paving way to introduce modern medicine while restricting traditional medicine practise (Kanenga, 2013).

Three years (3) after gaining independence, the nationalist government amended the British Act in 1967 by making it legal for traditional healers to practise traditional healing. Furthermore, recommendations were made that a national association of traditional healers be formed to regulate the practise of traditional medicine and a national council be formed to direct the affairs of traditional healers. The amendment was an attempt to encourage the growth and development of indigenous institutions as well as clean up the institution of traditional medicine to meet modern standards (Mulungushi Report, 1977). This led to the formation of Traditional Health Practitioners Association of Zambia (THPAZ) mandated to regulate and protect traditional healers as well as ordinary people from deceptive acts (Mvula, 2015).

1.1 Indigenous Knowledge and health care practises

Most African population, Zambia inclusive consult traditional healers and depend on indigenous medical knowledge for survival. This is noted from the estimations made by the World Health Organisation (WHO) that 70% to 80% of developing countries depend on traditional medicine for their primary health needs (Poorna, Mymoon & Haiharan, 2014). Most people in rural areas survive on traditional medicines when need arise especially in instances where hospitals are

very far away. Thus, preservation of IK is cardinal because it will ensure that knowledge on traditional medicines as well as the dosages is well documented and disseminated in the quest to protect lives and benefit the local people (Munsanje & Mulauzi, 2013).

On the other hand, estimations from Central Statistical Office and Ministry of Education indicate that most rural areas of Zambia have about 46% of residents living within a 5km radius of a health centre whereas many have to travel more than 50km to reach their nearest health facility. This indicates that access to modern medical care in more remote areas is not just limited by non availability of modern medication but further limited by national shortage of clinical staff has some health facilities are run by unqualified staff to cater for the population (MoH, 2019).

It can also be noted that even in places like Chibombo were health facilities are reachable by those living within 5km radius, some spiritual suspected illnesses require indigenous practises to administer the traditional medicine because modern medication and modern experts may have no idea and capacity to treat such illnesses.

1.2 Chibombo District

Chibombo district of Zambia is located in Central Province and shares boundaries with Chisamba, Kabwe, Kapiri Mposhi, Lusaka, Mumbwa, Ngabwe and Shibuyunji districts. The area has an estimated population of 224,215 as recorded by the Central Statistical Office (CSO, 2010). The district faces a number of health challenges such as inadequate health facilities, shortages of personnel, lack of equipment, stock out of drugs and low budgetary allocation which hampers delivery of primary health care. In addition, physical and economic barriers are major obstacles which people face in accessing primary health care facilities and services (Shikabi, 2013).

Chibombo district of Central Province in Zambia has a unique practise by the Lenje ethnic group called Mooba. It is a spiritual dance performed during events such as funerals, harvest time, healing sessions, as well as during installation of traditional leaders with an aim to appease the gods. The dance has been performed since time immemorial, and has been transmitted from one generation to the other through observation and practise of stated functions and events. Embedded in such practise is the spirit of acquiring, transferring and preserving IK by traditional healers who practise as well as train those who take up the mantle after them (UNESCO, 2017).

1.3 Statement of the Problem

Local people rely so much on indigenous knowledge to make their decisions on various aspects of their lives. This is related to the activities such as growing of food, preservation and preparation of food, medicines, their roles in society as males and females, etc. Some people in Zambia are not able to access formal education and as such may not be privy to conventional or scientific knowledge on how to do several things or make decisions (Munsanje & Mulauzi, 2013).

However, despite 70% of Zambian population heavily relying on consulting traditional healers and depending on indigenous medical knowledge for survival (Muyenga, Musonda & Chigunta, 2018), little is known about acquisition, transfer and preservation of indigenous knowledge by traditional healers in Chibombo district leading to negative perception towards the practise. This knowledge gap can be attributed to the fact that tradition medicine has remained largely under researched hence lacking awareness of its primary health benefits and cultural values (Goma et. al, 2016).

1.4 Purpose of the Study

This study intends to investigate the acquisition, transfer and preservation of indigenous knowledge by traditional healers in Chibombo District.

1.4.1 Specific Objectives

1. To explore how traditional healers acquire indigenous medical knowledge.
2. To establish how traditional healers transfer indigenous medical knowledge.
3. To identify the methods used by traditional healers to preserve indigenous medical knowledge.
4. To investigate the challenges associated with acquisition, transfer and preservation of indigenous medical knowledge.

1.5 Theoretical Framework

This study was guided by a four stage model proposed by Nonaka and Takeuchi (1995) called the SECI model. SECI represent the stages which are Socialization, Externalization, Combination and Internalization. The model was adopted in this study as it outlined the knowledge conversion processes (knowledge management) that better indicate a flow of knowledge from its unwritten form (i.e. tacit) to an expressive form (i.e. explicit) that allows replication and re-learning. In this study, the methodology used is supported by this model through socialization. The model clearly presented selection criteria that were based on purposive choices and spiritual interventions. What they learn therefore was expressed, combined and internalised among and within themselves for the benefit of the community and beyond.

Furthermore, the model supported the acquisition, transfer and preservation of indigenous medical knowledge. Firstly, participants acquired knowledge through socializing with the trainers who made sure that they master through observation or practising. Secondly, any form of knowledge learned during socialization was to be externalised through demonstration and mediation by the participants. Thirdly, what was taught through socialization had to be thoroughly combined with what was externalised, this meant that if a participant made a mistake when demonstrating, the trainer had to re-demonstrate thoroughly to train the participant.

Fourthly, everything learnt had to be kept confidential and ideas could only be shared among those who were part of the training.

II. LITERATURE REVIEW

2.1 Acquisition and Transfer of Indigenous Medical Knowledge

The acquisition of indigenous medical knowledge is stressed by Matsika (2015) when he urges that there are two ways through which one can become a traditional healer. Firstly is by personal choice, thus when one wants to be a healer and then goes to seek the services of a master healer to be trained under him or her. The second one is by being called to the job. The first one rarely occurs because not many people are willing to volunteer to be traditional healers as this demand more time and financial resources. It may also be the fear to be involved in the divine, the unknown world of spirits and magic (Matsika, 2015).

Additionally, Nyundu and Naidoo (2016) noted that traditional healers can be categorised into 2 types namely the sangomas and the inyangas. The sangomas are believed to be called by the spirits while the inyangas are mostly trained. However, although anyone can be called to be a sangoma the calling mostly follows a chain of families that had a member who at some point accepted the honour of becoming a sangoma in the past or present (Gcabashe, 2009).

A study conducted by Muyenga, Musonda and Chigunta (2018) aimed at surveying medical plants used in treatment of diabetes in Ndola's Chipulukusu compound of Zambia Furthermore, the study revealed that 20% of the traditional healers acquired their knowledge on traditional herbs from family members mainly the parents and grandparents; while 70% acquired the knowledge through the spirits and dreams and 10% through an apprenticeship. The study concluded that plant parts which were commonly used were roots and that all herbs were administered orally.

On the other hand, some individuals become traditional healers through training. What distinguishes the sangoma from the inyanga is the fact that while the former administers healing in various ways, goes through a strict apprenticeship and a formal initiation ceremony, the latter is more of an herbalist who does not undergo an initiation ceremony.

The training process is conducted by an experienced healer who specialise in training other healers (Maluleka, 2017). Thus the specialised healer in training is also referred to as the master in the event of knowledge acquisition. The training is commonly known to be a fulltime thing and the apprentice is expected to live with the master at his or her place for the duration of the training.

2.2 Preservation of Indigenous Medical Knowledge

Biyela (2016) conducted a study which looked at management and preservation of Indigenous Knowledge in Dlangubo village, South Africa. The results from the study revealed that the communityused memory and artefacts to preserve IK. Further, it was observed that some preservationstrategies had disintegrated or were gradually disintegrating like the culture of dryingof seeds and plants and the use of granaries. It emerged from the discussion withthe livestock keeping participants that although they still had knowledge about traditional medicinal plants and the types of ailments they cured but they were no longer used.

Agarwal (1995) talks of in-situ preservation, a process where indigenous knowledge is conserved by local communities for local communities. Kaniki and Mphahlele (2002) argue about the use of technology for preserving indigenous knowledge. Notable fact is that the uses of technology in preservation need to be taken into cognisance by library administrators, to ensure that appropriate measures for indigenous knowledge collection and preservation are put in place within responsible public institutions.

Maluleka (2017) conducted a study which looked at the acquisition, transfer and preservation of IK in Limpopo district, South Africa. The major finding of this study was that ancestors are believed to be the ones preserving this knowledge of traditional healing and they pass it down to the chosen ones through dreams, visions and so on. The study concludes that traditional healers also preserved their knowledge orally and commonly shared and acquire knowledge during interactions with other healers. It was concluded that key stakeholders should play an active role in ensuring that traditional healing is incorporated into the country's healthcare system.

2.3 Challenges during acquisition, transfer and preservation of Indigenous Medical Knowledge

IK is diminishing because of an increase in barriers that affect its transmission between and within community members. For instance in Kaliro district of Uganda people are over and done with methods on how traditional food plants is prepared to make sure that such plants are available for future generations, or how to prepare other traditional foodstuffs (Tabuti, 2004).

Barriers to preserve IK have been necessitated by inadequate documentation and the secrecy of custodians of IK. Some of the latter, especially traditional healers despise to disclose their IK on healing to strangers and to some members of their families. In Kaliro District of Uganda, some healers refused to make known their curative secrets to their daughters fearing that the latter would share the secrets with the families that marry them. Over time, IK fades away when its custodians die or migrate before their IK has been adequately transferred or documented. At present, much documentation of IK has been undertaken, especially in the domains of traditional medicine and traditional foods. However, many aspects of IK that includes the spiritual aspects remain undocumented (Maluleka, 2017).

Msuya (2007) conducted a study which looked at the challenges and opportunities in the protection and

preservation of indigenous knowledge in Africa, the results revealed that preservation of IK is difficult because it is in rare cases that you find it in written form. Msuya further argues that IK in this case follows the pattern of an African Educational that is conducted through transfer of knowledge orally from one generation to the next. The study recommended that each country should consider having appropriate policies that promote and provide guidelines on the innovation, conservation and preservation of IK.

Another study by Lwonga, Ngulube and Stilwell (2011) on the challenges of managing IK with other knowledge systems for agricultural growth in Sub-Saharan Africa in Tanzania. The study revealed that knowledge establishment theory can utilised in managing IK in the local communities provided there is sufficient and appropriate resources allocated for capturing and preserving it before it disappears. The study concluded that theexisting KM practices need to be strengthened for IK to be useful for agricultural development. Further, the study recommended that the communities need to be placed in a knowledge-creating surroundings that constantly creates, distributes and shares knowledge within and beyond the communities' boundaries and integrates it with new agricultural technologies, innovations and knowledge for sustainable agricultural development.

However resistance to change as well as poor knowledge sharing can be attributed to many factors that are mentioned in a study conducted by Zazu (2007) to explore opportunities and challenges for achieving the integration of Indigenous Knowledge System into environmental education processes in Zimbabwe. These findings revealed that some of the religions within the Sebakwe community viewed IK as pagan and unholy. The study concluded that in order to promote use of an integration of indigenous knowledge systems into the Sebakwe Environmental Community, the programme need to become more orientated towards a multi-cultural and bio-cultural approach to environmental learning.

III. METHODOLOGY

The study utilised 'hermeneutic phenomenology' as it investigated interpretive structures of experience of texts whether public, private in form of art or in other material forms (Grbich, 2007). Phenomenological research method was used because it explored the lived experiences of traditional healers who share the different experiences in their practice of traditional healing (Maluleka, 2017).The sample chosen for the study were 29 traditional healers registered with THPAZ as well as the headmen/women living within villages and chiefdoms of Chibombo District of Zambia; this was achieved through using snowball sampling. Data was collected through face-to-face in-depth interviews using a semi-structured interview guide and data was analysed thematically.

IV. FINDINGS AND DISCUSSIONS

Out of the 29 participants, 12 represented males while 17 represented females. Among maleparticipants, 2 were agedbetween 26 and 35 while 10 indicated being aged between 36 and above. In terms of years of practising, 2 indicated providing the service between 6 and 8 years while 10 indicated 9 years or more.

Among the female participants, 2 were aged between 26 and 35 while 15 indicated being aged between 36 and above. In terms of years of practising, 6 indicated providing service between 0 and 5years while 11 indicated 9 years or more. Table 1 below provides a summary of the above information.

Table 1: General Information of Participants

VARIABLES	VALUES	FREQUENCY
Gender	Male	12
	Female	17
Age	26 – 30 years	3
	31 – 35 years	1
	36 and above	25
Years of practicing	1 – 2 years	3
	3 – 5 years	3
	6 – 8 years	2
	9 and above	21

4.1 Knowledge Acquisition And Transfer

4.1.1 How participants became traditional healers

The study revealed two ways that took place to become a healer. The first one was through training (*mastering and practising; and demonstration and mediation*) which represented the majority of the participants (21). In this study, mastering and practising were an event where would-be healers observed attentively everything the trainer was doing and later practised without his or her guidance. One healer stressed that;

"I was trained by my grandfather who was a traditional healer, through observation I mastered everything he was doing. After a few years he allowed me to begin practising what I had mastered during his absence."

Another healer added:

"I was trained by my grandmother who identified and taught only me exactly what she used to do. I used to go with her in the wild to collect herbs, I mastered some and those which seemed confusing I documented for easy identification."

A study conducted by Muyenga, Musonda and Chigunta (2018) surveying medical plants used in treatment of diabetes in Chipulukusu Compound in Ndola found that 70% of traditional healers acquired the knowledge through spirits and dreams. These findings are different from those of this study

and this can attributed to the environment and how the practise is regarded.

Accordingly, demonstration and mediation presented a different scenario. Would-be healers were required to follow demonstrations done by the trainer step by step and after that, they would be asked to administer herbs to a patient while under strict observation and guidance. One healer narrated,

'I was trained to be a healer by my parents. They used to demonstrate on how to administer the herbs to patients. After some years, I began practising [mediation] in their presence while they observed.'

Another healer said;

'My mother was the one who trained me; she started when I was twelve years old. I used to go with her in the wild to dig, collect, pound and dry different herbs. When a patient seeking her help comes, she would call me so that I can hear the ailment and observe as she administers the herbs.'

These findings are supported by a study conducted by Zuma et al (2016) which revealed that during intensive process of learning about traditional medicines, the trainees act as mediators as it is one of the assumed roles for being custodians of traditional African religion and customs. Similarities can be attributed to the fact that in both communities, trainers protected their reputation by ensuring that those they train demonstrate to them what they were taught before they could go out and practise independently.

On the other hand, ancestral calling (*visions and dreams*) was the second process through which some participants became traditional healers. Ancestral calling involved a process through which a "called" healer received instructions through visions and dreams about different ailments and the type of herbs needed to administer. However, the instructions differed according to the circumstances within the community. For instance, the "called healer" would have revelations of a very sick patient in a far location and would be instructed on what should be administered for the patient to heal. Participants who became healers through this process were 8. These participants discerned the calling through four means which are sickness, revelation, confirmation as well as revelation and sickness.One healer urged *"I used to have a lot of visions. It became so worse that whenever I had the visions I would be unconscious for hours."*

Another one said,

"I had a dream once, in that dream everything I know and practise was revealed to me. I have never even learnt anything from anyone to date."

A study by Maluleka (2017) found similar results. In his quest to find out how healers became aware of their calling, findings revealed that sickness was a way through which those called were reminded that its time they needed to start practising. However, a study by Struthers, Eschiti and Patchell (2004) presented different findings. The findings from this study are different from their study in that, even though the same process was used to acquire the knowledge, there is no indication of sickness from the Struthers, Eschiti and Patchell's study.

4.1.2 Knowledge Transfer

The study revealed two ways through which knowledge was shared. Firstly, 15 participants indicated using *demonstration and observation*. This process meant that the trainees learnt through observing whatever the trainers were doing. 6 participants indicated using *demonstration and practise* as a means through which to transfer knowledge. Demonstration and practise in this study referred to the process where trainees were required to practise everything the trainers demonstrated while being observed. However, a number of participants (8 healers) indicated not doing anything relating to knowledge transfer at the time of the study. Some of the reasons cited were that they had no one to transfer the knowledge to as their children were still very young, some indicated that the practise was too sensitive to share it, while others added that there was no need as most people seemed not interested. A healer under demonstration and observationsaid that,

"Through demonstration, I trained my child how to identify, dig and process herbs as well as helping her to know which illness require what herb to be gotten led off. This was done through going with her in every step as she observed."

Under demonstration and practise, a healer added that,

"I feel demonstrating if done in good faith [without hiding from those being trained] is a powerful way of teaching. Just like I was trained in the old days, I also demonstrate and later observe each trainee one by one as they practically show their knowledge level in my presence."

These findings are similar to Barnhardt and Kawagley (2005) results which showed that indigenous knowledge was transferred through demonstration and observation. These similarity can be attributed to the fact that the method used made it easier for those learning to adopt the lesson.

4.2 Knowledge Preservation

Indigenous Medical Knowledge gained over the years was preserved by participants for future use; the study revealed that majority (22) of the participants' was*training* relatives or other interested individuals as a way of preserving the knowledge. In this study, training meant an act of preparing one for a role through teaching them the needed skills and required behaviour for the practise. However, 7 participants indicated that they were *not doing anything* to preserve the knowledge. The participants highlighted that the current environment provides less support for traditional healing hence not many were willing to be trained for future continuity. Furthermore, other participants who were willing to preserve the knowledge through passing it on faced challenges as their children were very young. One healer

alluded that *"I have been training my children for the past 2 years. I have witnessed them administer herbs to different patients with different illnesses. I know that even if I am no more today, they will continue practising what they were trained in. Due to the negative perception of the practise from our society, I have not engaged non-relatives in the training even though most of them have shown interest."*

Another one added:

"For now, I am not doing anything that relates to preservation. I would really love to train my first born daughter but looking at the environment and how it perceives our practise, it draws me back."

A study by Olatokun (2010) aimed at revealing indigenous knowledge of traditional medical practitioners in the treatment of sickle cell anaemia in South-western Nigeria found similar results. Thus the knowledge of traditional medical practise was orally preserved and transmitted by word of mouth from generation to the next. The similarity of the findings can be attributed to the tacit nature of the knowledge.

4.3 Challenges when acquiring Indigenous Medical Knowledge

The study revealed four challenges that participants faced during knowledge acquisition. The first one was sickness which accounted for 6 participants; difficulties in mastering were represented by 5 participants. Segregation and panicking were accounted for 1 participant and 2 participants respectively. However, the majority healers (15) stressed that they did not face any challenge during acquisition. Different situations necessitated the challenges highlighted above. Sickness was induced to bring an individual to the realisation that the spirit had chosen him or her to take up a role as a healer. Accordingly, sickness was also induced in order to remind those who abandoned the calling for different reasons. Secondly, difficult in mastering meant that some among the trainees were slow learners or had challenges to identity most herbs used. Thirdly, participants had difficult adapting a new life in a new environment. Fourth, panicking was necessitated by patients' not reacting positively to administered herbs by trainees.

One of the healerswho discerned the calling through sickness narrated that,

"The most challenging thing during acquisition was when I got sick. My parents tried whatever they could to help me get better but to no avail. Until a healer was called to help, that is how I was healed"

Another healer added,

"The challenge I faced was when I got mad for 8months. I was even separated from the community and I lived in the bush. This was my terrible experience especially when I hear people and parents narrate the story to me."

A similar study by Maluleka (2017) revealed that among the would-be healers one came in very sick, she could not walk. Findings further showed that she was told she had a calling by another healer a few months but ignored and decided to seek second option. These findings compliment the finding from this study, the similarity can be attributed to the fact that though the sickness is induced differently, it is one big sign the ancestral spirits use to remind the 'called' about the practise.

4.4 Challenges when transferring Indigenous Medical Knowledge

The study revealed four challenges that participants faced during knowledge transfer. The first one was unwillingness to learn which accounted for 8 participants; those who indicated jealous were represented by 4. Time consuming and lacking help was accounted for 2 participants respectively. However the majority healers (15) stressed that they did not face any challenge during transfer. Different situations led to the challenges listed above. Firstly, unwillingness to learn meant that most healers portrayed a "know it all" behaviour which made it difficult for them to learn from their fellows. Additionally youths and some relatives sidelined the practise citing that it has been rendered unnecessary in the face of modernity. Secondly, cheating on one another in order to put them out of business was common, different belief systems and procedures for practising also acted as a barrier to knowledge transfer. Thirdly, some trainees took more time than usual to be trained and fourth, absence of helpers who were trained in the practise proved to be a challenge for some healers.

One of the healers who cited jealous as barrier to knowledge transfer narrated that,

"Jealous is what makes the transfer of such knowledge difficult because some fear that transferring may make one more famous than they were. For instance, my fellow healers have changed my phone number on my banner several times just to misled patients, as if that is not enough, the banner I am currently using is the fifth one because the last four were all stolen. I am very sure that it's my fellow healers who are doing this because mere people are afraid of us and what we practise."

One healer added,

"Jealous is the common challenge, there is a lot of cheating amongst healers which then act as a barrier to the transfer of knowledge."

A study by Bagwana (2015) asserts that barriers to preserve indigenous knowledge have been necessitated by the secrecy of custodians' especially traditional healers who despise to disclose their indigenous knowledge on healing to strangers and to some members of their families. Attribution to the similarities may be as a result of respecting the practise as an honour within families and a confidential gesture.

4.5 Challenges when preserving Indigenous Medical Knowledge

The study revealed three challenges that participants faced during knowledge preservation. The first one was unwillingness which accounted for 8 participants; those who indicated spirituality were represented by 1participant. 1 participant accounted for expiration while the majority healers (19) stressed that they did not face any challenge during preservation. Unwillingness in this study meant a situation where most individuals show no concern about learning the practise. Further, those trained showed signs of forgetting what they were taught to do. Secondly, expiration meant the process by which herbs kept for long without being used lost healing power due to changes in wheather pattern. Thirdly, spirituality implied a scenario where the healer practised only when he or she was possessed by the spirit. This made preservation difficult as one hardly remembered all they did when they were possessed.

One of the healerswho cited unwillingness narrated that,

"Most of the people are not willing to learn or be trained in this practise; this can be observed from how fast they forget when we teach them. For instance I have ten children and I have trained all of them, unfortunately only four have mastered and seem interested."

Further, another healer added,

"My children have shown no interest about learning the practise skills. They have since sidelined themselves from me and their mother."

A study by Tabuti et al (2004) showed that indigenous knowledge was acquired and transferred by the willingness to verbalise and share by custodians. The authors further observed that indigenous people were not constantly willing to share this knowledge with people from outside their communities. The findings from the study above are different from those of this study. On one hand, this study indicated willingness from the knowledge custodians to share the knowledge to the unwilling relatives while on the other hand, the above study proved the opposite as custodians were not willing to share such knowledge to any outside their communities regardless of family ties. The difference can be attributed to the values upon which both societies place on indigenous knowledge.

V. CONCLUSION AND RECOMMENDATIONS

While many traditional healers took part in revealing the process through which they acquired, transferred and preserved indigenous knowledge on healing, some still felt that the practise and all its processes were very confidential to be shared.

The need for community leaders in Chibombo district to consider educating the local youths during ceremonial gatherings on the need to acquire and preserve indigenous practices was recommended. This was seen as a way through which unwillingness to learn and share would be reduced. Secondly, it was recommended that collaborative efforts between community leaders and traditional healers to document most of the indigenous medicine and the ailments they healed be strengthened. This was seen as a way through which difficulties in mastering and panicking among the would-be healers reduce. And thirdly, it was recommended that Lenje Cultural Association consider documenting and disseminating information to the local people through showcasing what is available in the Mukuni Culture Village Museum and Library. This was seen as a way through which many youths would be encouraged to appreciate the indigenous values in their culture.

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