RESEARCH REPORT

Choices of health service providers by a community that is generally not exposed to psychological services

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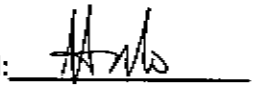
DECLARATION

I declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts by Coursework and Research Report in the discipline of Community-Counselling Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

Signed: 

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Date: 22/07/2010

1. Acknowledgements

- To the Kathorus community sample that participated in this research study; especially the focus groups participants for sacrificing weekend niceties in order to attend discussions; and
- To the Khumalo clan's latest additions, Refilwe Trudy and Sbonelo Thabani.

2. Abstract

This survey assessed how a sample of a Black township community in the East Rand would choose among mainstream and traditional health service providers. These choices were made and accounted for in the questionnaire. To elaborate on these accounts, two one-hour focus groups were conducted. The questionnaire was constructed and piloted before it was administered. Focus groups discussions were video-recorded and transcribed. Transcripts were analysed using content analysis and by adopting the memo. Results showed that both traditional and mainstream health care services and practices were used. Mainstream health service providers were perceived to be helpful in treating mainly 'physical' and some psychiatric conditions. Traditional healers would be consulted for conditions that were considered to have supernatural causes primarily *ukufa kwabantu*. There were varieties with regard to the use of both mainstream and traditional healers that were associated with individual orientation towards modern, traditional and postmodern ways. To accommodate multiple health seeking practices, patient-centred health care was recommended. The person using the service would help direct the treatment plan in an environment where people consult health service providers they consider appropriate for treating that condition. This environment would facilitate open communication among health service providers themselves and people consulting health care services.

3. Table of Contents

Chapter 4: Results

Chapter 5: Discussion

Chapter 6: Conclusion

4. List of Tables

Chapter 1: Introduction

1. Introduction

There has been a struggle to make mental health resources available to all South Africans (Stead, 2002). One of the clearly identified priorities was to transform (Holdstock, 1981) or to restructure the health care system, including mental health care (Freeman, 1990, 1992; Pillay, 1993; cited in Pillay and Petersen, 1996). This transformation intended to broaden the mainstream approach to health and healing, i.e. the medical model (Seedat & Nell, 1996; Jilek; 2002; Burman, 1996). The psychophysiologic basis of illness was reviewed (Jilek, 2002). It was found to be insufficient in dealing with diverse needs of multicultural societies (Jilek, 2002). Firstly, that physical illness does not equal mental illness (Jilek, 2001). Rather, physical illnesses have psychological and emotional sequelae (Williams and Healy, 2001). More importantly, social and cultural factors influence the cause and the course of the illness condition (Jilek, 2001; Burman, 1996; Pillay and Petersen, 1996).

Suggestions encouraged culture sensitive medical consultations (Ellis, 2002); i.e. to incorporate into mainstream health care, cultural and critical understanding of illness and healing (Petersen, 1998; Modalvsky, 2004; Beiser, 2003). Kleinman's (1980) 'explanatory models' lead a meaning tradition, an illness approach to health and healing (Petersen, 1998; Good et. al., 2001). It proposed that the treatment plan should be in consonant with the person's illness experience (Petersen, 1998; Good, Good and Becker, 2003). This would be twofold. Firstly, culture sensitivity and culture-congruent care would be taught among health service providers (Jilek, 1998; Good, Good and Becker, 2002; Kgwatalala, 2003; de Villiers and Harselman, 2004). It also proposed to outsource health care services to health service providers that are perceived to treat particular conditions best, hence treatment packages (Katz and Wexler, 1985, cited in Ebigbo, 1995).

2. The problem

In designing the health care system that would be adaptable to multicultural needs, Hamber and Rock (1993) acknowledged that health service providers would implement changes. Miller and Swartz (1996) indicated that the knowledge of the nature and the prevalence of illness conditions would be imperative. The illness model suggested a partnership between healers and the person using the services; hence patient-centred health care (William & Healy, 2001). Along the lines of the illness approach to health and healing, what has been missing is how under-resourced communities (Rock & Hamber, 2004) engage health systems (MacKian, 2003)?

3. Rationale

The knowledge of which health service would be preferred for particular conditions would inform treatment packages (Katz & Wexler, 1985, cited in Ebigbo, 1996). Treatment packages broaden a multidisciplinary approach (Miller & Swartz, 1996) to health and healing. They suggest a unified treatment schedule, where there would be cross-referrals among health service providers of all modalities (Katz and Wexler, 1995, cited in Ebigbo, 1996). Treatment packages promote an open communication in an environment where; a) consulting health service providers would be in consonant with the illness experiences of the person consulting health services (Kgwatalala, 2004; Petersen, 1998; Good et. al., 2001); and b) health service providers would treat conditions they are considered to be best at treating (Katz & Wexler, 1995, cited in Ebigbo, 1996).

In a developing country, all available resources would need to be utilised (Hamber and Rock, 1993). The issue would be how best to allocate them (Holdstock, 1979). Utilisation studies proposed that communities have strategies that they engage, as a collective, in seeking health

care (MacKian, 2003). These strategies should be incorporated in the health care delivery plan (MacKian, 2003).

In multicultural societies, pluralistic tendencies were observed when it comes to seeking health care (Miller and Swartz, 1996; Swartz, 1998; Bodibe, 1993), i.e. there are co-existing options; mainstream and traditional health systems (Kaptchuk and Eisenberg, 2001). With regard to the delivery of equitable health care services, the question would be what to do when both agencies are available to the client (Cheetham and Griffiths, 1982; citing Lambo, 1966 and Bolman, 1968)? This would inform policy formulation, especially the imminent integration process.

The knowledge of whom communities would prefer to consult in times of distress contributes towards a knowledge base that would support culture-congruent care (Kgwatalala, 2004; good, et. al. 2001). Culture sensitive health care seeks to minimise discrepancies between 'the illness' and 'the disease.' Illness is the conception of the person's own suffering as opposed to 'the disease', which is the conception of the same sickness by the medical model (Swartz, 1995). It was proposed that approximating these paradigms is associated with concordance than compliance (William and Healey, 2001). The person would help design the treatment plan than being expected to follow a treatment regime.

4. Research questions

A person consulting health services would not be a passive agent. The illness approach to health and healing held up 'putting man [and women] back to social sciences' (Atal, 1977). In social sciences, how communities use health care service would be associated with interest in studying reflexive communities. In particular, how these communities reflect particular

ways of behaving and thinking and reaching decisions of individuals or groups (MacKian, 2003). These ways reflect the social construction of their position in wider society at a particular place and time (Lash, 2000, cited in MacKian, 2003).

To understand how a Black township community use health care services; this research study answered two questions; viz.

1. Who would a sample of a Black township community consult among mainstream and traditional health service providers with regard to medical, psychiatric and culture-bound conditions?
2. How would this sample account for particularities they place on consulting health service providers they chose?

5. The nature of the study

This study was a survey. The questionnaire was constructed, piloted and administered to a sample of 60 respondents. Respondents were approached in their houses, and only those who were available answered the questionnaire. 17 people volunteered to participate in two one-hour focus groups.

Data was both quantitative and qualitative. The basis of analysis and interpretation were descriptive entries of a number of respondents who chose health service providers according to categories of conditions. Focus group transcripts were analysed using the content analytic technique, i.e. the conceptual matrix (Krippendorf, 1980; cited Stemler, 2001). To assist analysis, the focus group data representing technique, the memo was also adopted (from Wilson, 1985; cited in Morgan and Kreuger, 2001).

6. Theoretical framework

A number of factors would influence the choice of health service providers one would consult in times of distress. These include situational, personality, gender, economic, and cultural factors. Other than these factors, the belief model (HBM) proposed that beliefs contribute on which health care system would be utilised. It is usually contrasted with social cognition models that propose that choice would be a rational process; and these models have been accused of being one-sidedly cognitive. In choosing health care system, there would be less easily identifiable affective-emotional processes (Lash & Urry, 1994, cited in MacKian, 2003).

The illness models as opposed to the disease approach to health and healing illustrate the move towards the bio-psycho-socio-cultural approach to health and healing. These models encourage explanations and treatment that are consonant with the culture and worldview of the client (Kgwatalala, 2004; Cheetham & Griffiths, 1982). They encourage the provision of patient-centred health care (Williams & Healy, 2001). Treatment packages (Katz & Wexler 1995) broaden a multidisciplinary environment (Miller & Swartz, 1996) in multicultural societies. They propose the inclusion of the traditional healing methods and practices to an integrated health care system.

7. The research report: Outline

Chapter 2 discusses the theoretical framework from previous literature on appropriate health care delivery in multicultural societies including ethnic minorities in developed countries. Chapter 3 presents research design and methods. Findings are on Chapter 4, followed by discussions on Chapter 5; where implications of these findings are discussed. Chapter 6 deals

with concluding comments, which involve strengths and limitations of this study, as well as recommendations for future studies.

8. Conclusion

With regard to the delivery of health care services in culturally diverse societies like we have in this country; there is an interest in the concept of social capital (MacKian, 2003). It is an idea of how intervention strategies should be sensitive to local dynamics (MacKian, 2003). This is in line with the WHO's recommendations of the use of safe and local solution to local problems. Painter and Terre Blanche (2004) pointed out that though local solutions are desirable they must also be sensitive to global trends.

CHAPTER 2: Literature Review

1. Introduction

In situations where both mainstream and traditional health care systems are available; Kleinman's explanatory models of illness experience suggested that the experiences of the person using the services would be the basis of a treatment plan (1980, cited in Petersen, 1998; Good et. a., 2001; Jilek, 1999). Patient centred health care proposed a partnership between the health service provider and the person consulting health services in determining that treatment plan (William & Healy, 2001; cited in MacKian, 2003). To determine the suitability of the treatment plan and to make appropriate referrals; culture-congruent care proposed ways to achieve an in-depth interview in multicultural consultations (Karlsson & Moloantoa, 1984). 'Treatment packages' suggested a unified treatment schedule (Katz & Wexler, 1995; cited in Ebigbo, 1996); i.e. a relationship between mainstream and traditional health service providers.

With regard to which health system an individual may use, social cognition models proposed that making this choice would be a rational process. Information sources and how they would be interpreted would therefore be fundamental in understanding health-seeking behaviour. Individual factors like gender, age, and socio-economic factors would also be crucial. Situational factors may involve the nature of the condition, the need for health care, geographical proximity to health care services, the perceived quality of care (Tipping & Segall, 1996; cited in MacKian, 2003) as well as the availability of advisers and experts (Swartz, 1998). Knowledge-Attitude-Belief-Practice (KABP) models acknowledge the rational process, but highlight the less obvious emotive, experiential factors. The health belief model proposed that a person consults health care services because they are congruent with the person's worldview and the belief system.

2 Social cognition models

The process of responding to illness has also been studied in social cognition models (Conner & Norman, 1996a; cited in MacKian, 2003) that predict possible health –seeking behaviour patterns. The KAPB models (Knowledge-attitude-belief-practice) propose that health seeking behaviour is a rational decision making process based on information and knowledge (MacKian, 2001). When an individual makes a decision in relation to their health, they weigh up potential risks and benefits of a particular behaviour. But they do so according to MacKian (2003), mediated by their practical environment, their social rootedness and their whole outlook in life. The assumption is that behaviour is best understood in terms of an individual's perception of their social environment. So, accessing health care services is a decision on who is consulted in times of distress and suffering; an outcome of a discourse between what is available and what an individual believes is going to help.

3 Factors influencing choices among health systems

A number of factors would determine which medical system an individual may use. Among these are individual, situational, and socio-economic factors. Individual factors are age, gender, level of education, and the person's social status. Situational factors include the availability of services, the availability of helpers or experts and the type of the illness condition. Two models propose information processes underlying choosing a particular health system. These are the social cognitive model and the health belief model. Both these models view a choice of health service system as negotiating what a person needs and what is available.

3.1 Availability of health care services

Access to health care services would be determined by the geographical proximity to services. It would be determined by familiarity with health care services and the ability to afford these services. Gureje, Acha and Odejide (1995) studied pathways to psychiatric care in Nigeria. They concluded that pathways to psychiatric care reflect the need for health care services and the nature of the services available. Gurley (2001) compared use patterns across biomedical care and traditional healing options among American Indian veterans. Gurley (2001) found that when the full array of options is examined, service use functions according to need for health care, but the kind of services used vary according to availability.

3.2 Individual factors

Access to health care would be collective but that there are individual factors that affect the decision to engage with a particular medical channel. These would be a mixture of demographical, social, emotional and cognitive factors, perceived symptoms, access to care and personality. They also include gender; and more in particular the status of women in the society (MacKian, 2003).

3.3 Situational and immediate environmental factors

For Swartz (1998), the decision on an appropriate health service provider would also depend on the availability of advisers or experts. The role of support structures, family, friends, the church, the pastor, etc. may play a role on making this decision. But that the nature of the conditions would determine the nature of health care services that would be consulted (Miller & Swartz, 1996; MacKian, 2003; citing Goldman & Heuveline, 2000).

4. The Health Belief model

Health belief model (HBM) is a concept described in a nutshell as an assumption that if you don't believe in the treatment, then you are not going to take it (Ellis, 2001). The widely applied 'health belief model' by Sheeran and Abraham (1996) categorised the range of behaviour into three broad areas: preventive health behaviour, sick role behaviours and clinic use. It regards individual beliefs to offer the link between socialisation and behaviour (Becker, Radius & Rosenstock, 1978). The health belief model focuses on attitudes and beliefs of individuals in predicting consulting behaviour.

In deciding whom to consult, HBM predicts that the perceived nature of the condition is important. Secondly, that familiarity with the healing method and the health service providers brings along expectations on the treatment and the management of the condition of distress. Lastly, it is the individual belief on the efficacy of the treatment that would influence the likelihood that a particular method of healing is considered.

Traditional conceptualisations of mental health, ill health and other misfortunes in African cosmology are beliefs that sickness or misfortunes are caused by some agent or event external to the individual or the group (Stricklin, 1990, citing Mutwa, 1946; Kruger, 1974; Hammond-Tooke, 1974, 1975; Ngubane, 1977; Chavunduka, 1978; Gelfand, 1965, 1964, 1977; Schweitzwer, 1980; Wessels, 1985). Conditions of suffering are in Africa attributed to external causes, i.e. ecological hazards, the evil and the evil eye/evildoer is the attribution of events to external causes (Ebigbo, 1996; cited in Phillips, 1996). '... breaking rules of the deity can lead to illness', 'a frightening thing will happen to you', so generally a corrective or a preventive cultural and religious ritual would then be necessary. Causality is non-linear and may be due to some ancestor or ancestors who have withdrawn their loving support; or from

some witch; who would also be an unfriendly person in the community (Azibo, 1993; cited in Phillips, 1996)(p.117).

5. Explanatory models of illness: the illness approach

Mkhwanazi (1986, citing Mkhize, 1981) maintains that in a particular cultural group any healing system that attempts to understand a person in terms of his own worldview will be experienced as enriching and meaningful. This is an approach to healing distinguishable by an emphasis on the illness experience in the healing process or according to Petersen (1998) the subjectivity of the illness experience. For Petersen (1998) this is a meaning centred tradition; based on the explanatory models of illness (Kleinman, 1980, cited in Petersen, 1998; Good, et. al., 2002; Swartz, 1998; Swartz, 1987, cited in Miller & Swartz, 1992).

An explanatory model of illness refers to how a person interprets an illness episode in terms of cause; description of precipitating events and initial symptoms; description of the sickness; expected course of the sickness; and understanding of available treatment modalities (Hahn, 1995; cited in Petersen, 1998). Illness is the subjective experience of the condition (Miller & Swartz, 1992). It is contrasted with the disease, which is conceived as the biological component and in biomedicine, the practitioner's conception of the sickness. The approximation of the illness and the disease models in any healing encounter is the essence of awareness and healing. This is an incorporation of the existential dimension of human suffering (Kleinman, et al., 1997; cited in Modalvsky, 2004) as central in healing.

6. Culture-congruent health care: Responding to 21st century health care

The biomedical approach to health and healing, i.e. the physical basis of disease has been dominant in mainstream health care (Fernandez & Kleinman, 1992), including mental health

(Papaikonomou, 1991). There are enormous benefits in this model (Papaikonomou, 1991). But that the marginalisation of illness with regard to disease (Miller & Swartz, 1992) had been insufficient in providing health care needs for the majority South African. 'Physical' illnesses have psychological and emotional sequelae (Williams & Healy, 2001). But, physical illness does not equal mental illness (Hamber & Rock, 1993) rather; that there are socio-cultural factors in mental illness. A biopsychosocial approach (Engel, 1897; cited in Miller & Swartz, 1992) to health care was suggested and it encouraged a multidisciplinary approach to health and healing (Miller & Swartz, 1992).

The illness approach to health and healing has implications for doctor-patient relationships (MacKian, 2003). This is a view that an understanding of the worldview of the client as she (the client) sees it is a primary requisite in affecting a meaningful therapeutic change (Mkhwanazi, 1986). In order to accommodate the diversity of cultural conditions as presented by clients and patients from ethnically diverse backgrounds (Good et. al., 2002), cultural sensitivity (Yen & Wilbraham, 2003) and competence (Good, et. al., 2002) are indicated. This is where healers learn to handle both the biological and sociocultural aspects of the disorder (Modalvsky, 2004). Culture sensitivity and culture congruent health care is advocated; hence patient-centred care. There are two basic tenets behind this model: 1) The treatment plan should be in consonant with the worldview of the client; so that 2) health service providers can treat the conditions they are perceived to be best at treating. This model is geared towards facilitating an environment capable of offering treatment packages, by informing the integration process.

According to Kirmayer and Minas (2000), a cultural perspective can help clinicians and researchers become aware of the hidden assumptions and limitations of current psychiatric

theory and practise. Clinicians can identify new approaches appropriate for treating the increasingly diverse populations seen in psychiatric services around the world. Good, Good and Becker (2002) referred to the 'unlearning of the medical gaze.' It is achieved by a close examination of own preconceived notions and feelings due to the students' socialisation (Good et. al., 2002) especially in the biomedical tradition. In a therapeutic encounter a clinician would seek the exploration of multiple layers (Good, et. al., 2002). The healer co-constructs with clients narrative versions that are both meaningful and acceptable in all senses (Eagle, 2004).

7. Treatment packages: Integration

Katz & Wexler's (1985) proposed an idea of 'treatment packages.' This is a unified treatment schedule where there are cross-referrals among health service providers of different codes or orientation. Traditional health services can be effective and cost-saving means of providing culturally meaningful health care to the public, which has continued to use its services both with and in the absence of modern medical services (International Symposium on Traditional Medicine, 2000). Mental health professionals in South Africa (le Roux, 1973; Kruger, 1974; Cheetham, 1975; Bührmann, 1977; Gardener, 1978) called for the greater recognition to be given to the greater use made of the skills of the indigenous healers in the treatment of the persons who could benefit from their services (Holdstock, 1979; Sokhela, Edwards & Makhunga, 1985). Various researchers, academics and clinicians have recommended a form of co-existence [appealing for recognition of traditional healing] that will help avail traditional healing services to the needs of the people who use them.

According to the WHO (2000) the relationship between modern and traditional medicine has taken four broad forms:

(a) a MONOPOLISTIC situation, where modern medical doctors have had the sole right to practice medicine;

(b) a TOLERANT situation, or one of CO-EXISTENCE where traditional medical practitioners, while not formally recognised, are permitted to practise in an unofficial capacity;

(c) a PARALLEL or dual health care model, as in India, where both modern and traditional medicine are separated components of the national health system; and

(d) INTEGRATED model, where modern and traditional medicine are integrated at the level of medical education and practice (e.g. China, Vietnam).

To create and environment conducive to treatment packages, a managerial and regulatory intervention would be needed (MacKian, 2003). Integration is imminent and the government has so far halted any form of integration pending more research studies (DOH, 2001).

8. Conclusion

In restructuring the health system (Hamber & Rock, 1993; Pillay & Petersen, 1996; Petersen, 998), a vision has been generally understood that the development of services would strive towards promoting a state of physical, spiritual and emotional well-being. Not only the physical disease process would determine this but also social, cultural and material conditions. Petersen (1998) suggests that our multicultural society demands a discourse of care, which takes into cognisance different cultural formations of illness and treatment modalities. Health care is presented here to strive towards an approach that accommodates a variety of conceptions of illness and healing.

Chapter 3: Methodology

1. Introduction

This was a survey of choices a sample of a Black township community made with regard to consulting health service providers. In a questionnaire, respondents chose health service providers they would consult or advise someone to consult. These choices were made according to three categories of conditions, viz. medical, psychiatric and culture-bound psychiatric conditions. In each of these choices respondents explained why a particular health service provider was best suited to treat that particular condition. Focus group discussions elaborated on these accounts. These choices and accounts for making them were then contrasted among health service providers, i.e. mainstream and traditional healers.

Table 1: Research design table

Research Questions	Sample	Data Sources	Instrument(s)	Data Analysis	Interpretation	Reliability and Validity
1. Who would a sample of a Black township community consult among mainstream and traditional health service providers with regard to general medical, psychiatric and culture-bound conditions?	1. Black township community (60) 2. Non-parametric	1. Questionnaire responses – close ended	1. Demographical information – age, gender, annual salary; and the level of education 2. Selecting health service providers according to 28 conditions	1.Frequency count	1. Descriptive	Triangulation – use of multiple and complementing data sources
2. How would this sample account for particularities they place on health service providers they chose?	1. Black township community (17) 2. Volunteer	1. Questionnaire responses – open ended 2. Two one-hour focus groups – open ended	1. Explains in the questionnaire why that selected health service provider was best suited to treat that condition? 2. Focus groups discussed why particular health service providers are consulted?	1. The memo 2. Content analysis - conceptual analysis	1. Descriptive 2. Descriptive-inductive	Triangulation – use of multiple and complementing data sources; i.e. the questionnaire and focus groups

2. Research Design

The 31-item questionnaire was constructed and piloted before administration. Focus groups were video-recorded and transcribed. These transcripts were analysed using the memo (Wilson, 1995; in Morgan & Kreuger, 1996) and content analysis (Krippendorf, 1980, cited in Stemler, 2001). Reliability and validity was assured by using triangulation, i.e. using several sources of data, viz. the questionnaire and focus groups.

2.1 Sampling

Members of a Black township community were approached door-to-door in their houses. Only those who were present at home answered the questionnaire. Respondents were not randomly selected. Although all respondents were invited to focus groups, 17 participants attended focus groups discussions because they could; making this a volunteer sample.

2.2 The sample

The sample was selected from the Kathorus Black township. This township is located on an average of 20 km away from a major town, Johannesburg and an average of 15 km from small towns like Kempton Park, Alberton, Germiston, Boksburg and Benoni. To accommodate increased urbanization, a result of high need for manual labour in mines (Eighty 20, 2004); the Alberton City Council bought a farm to build these townships; mainly. Initially, these were 'old township stock' houses (Eighty20, 2004), as they are known now, that as the time informal squatter settlements, e.g. Zonkizizwe, Phola Park, etc. mushroomed around them. The private sector also contributed in building houses hence the mergence of the middle-income and few high-income houses (Eighty 20 Databases, 2004). According to the segregation rules of the former government, these townships are located next to Indian

(Palm Ridge) and coloured (Eden Park) townships, that were built to accommodate forced removals in Edenvale (South African Tourism, 2004).

Till the early nineties a full-time psychologist had not been available (Freeman, 1990). From personal communication with psychologists; public psychologists are presently based at Ekupholeni. This is a wing in the Natalspruit hospital that further visits different surrounding clinics (Phola Park, Kathlehong and Vosloorus, for example). There are several public (Natalspruit and Vosloorus Hospitals) and private hospitals (e.g. Clinix™, Union™, Garden Home™, etc.), with numerous private practices in this township and surrounding towns and a city mentioned above. Two assumptions are made about this community, viz. that they can access both traditional and western health care, but formalised mental health care. This is largely because of this community's geographical location and the centralised nature of formal health care services in this country.

2.3 The instrument

Respondents answered a 31-item questionnaire, and two focus groups. Demographical information assessed was age and gender. Respondents' socio-economic status was assessed using information on the employment status, the level of education and the respondent's annual salary.

2.3.1 Constructing the questionnaire

The questionnaire was constructed. A choice of categories of conditions was made first, then the health service providers to include. It also involved deciding on the administration procedure.

2.3.1.1 Selecting conditions

Medical, psychiatric and culture-bound psychiatric conditions were selected from various sources. Culture-bound psychiatric conditions are presented in a language accessible to the western-trained professions [Edwards, et. al., (1995); Ngubane, (1977); Bührmann, (1984); Green, (1995); Bodibe, (1995); Lund & Swartz (1998); & Bates, 2001]. *Ufufunyane* (Stones, 1996), *idliso* (Bührmann, 1984; Edwards, et. al., 1985), *ukuthwasa* (Long & Zietkiewietz, 2001), *umnyama* (Felhaber, 1986), are some of the conditions that have received attention largely because of their situation at the cross between psychological, medical and cultural facets of culture-bound psychiatric syndromes. Sotho and Tswana terms for these conditions were sourced from Bodibe (1995); Xhosa and Zulu terms from Ngubane (1977) and Bührmann (1984), with the initial list selected from the taxonomy of culture-bound psychiatric syndromes in Edwards et. al. (1985).

Table 2: Categories of conditions; and conditions selected for the questionnaire

Category of conditions	*Definition*	*Sources*	*Conditions*
Medical	'physical' and medical conditions	MacKian (2003); Green (1995)	Asthma; cold and flu; HIV/AIDS; Diarrhoea; Constipation; STI's; gonorrhoea; cancer
Psychiatric	'Universal' sense of conditions of distress to both traditional and western nosologies – Disease perceive to have cognitive and emotional sources	Bodibe (1995)	*Umsangano*; *ukuphambanelwa ikhanda* in Zulu or *segaswi* in SeSotho; *ukuphatheka kabi* (major depression), *ufuna ukuzibulala/hobatla hoipolaya* (suicide ideation), *ukuthuka/tshowa* (panic attacks) and *uvalo* (anxiety [attacks])
Culture-bound psychiatric	Conditions perceived by African people as peculiar to African people and best explained using the African cosmology	Edwards, et. al. (1983); Green (1995); Bührmann (1984); Ngubane (1977); Peltzer (1995); Lund and Swartz (1998); Bodibe (1995).	*Ufufunyane*, *ibulawo*, *umhayizo*, *umnyama*, *ibhadi*, *ukudlula*, *idliso*, and *umeqo*

2.3.1.2 Selecting health service providers

According to conditions selected, four health service providers were chosen to represent mainstream and psychological services, i.e. the medical doctors, psychiatrists, psychologists

and social workers. Traditional healers were represented by *inyanga*, and *isangoma* and they include the prophet/*umprofithi*. The prophet, as literature suggested may at times double as a priest in some cases. For conditions that respondents may need a different health service provider other than the one provided, a category 'other' was also included.

Table 3: Health service providers selected for the use in the questionnaire

	Mainstream health care	Traditional health system	Other
Health service providers	Medical doctors, psychiatrists, psychologists, and social workers	*Inyanga* and *isangoma* (Bodibe, 1995, citing Durie and Hermansson, 1990; Edwards, et. al. (1983)	Health service providers and health care plans not provided for by the list, e.g. specialists, alternative and 'exotic' practitioners, etc.
		Umprofeti, priest, friends and family members (Stones, 1996; Kgwatalala, 2004; Bates, 1995)	

2.3.1.3 Administering the questionnaire

Respondents were approached in their houses. The researcher obtained consent and explained to the respondents the procedure in answering the questionnaire. From the list of health service providers, respondents chose according to conditions the health service provider they would chose. For easy access, this list was furnished on top of each page of the questionnaire. Line spacing was doubled to accommodate handwritings of different shapes and sizes.

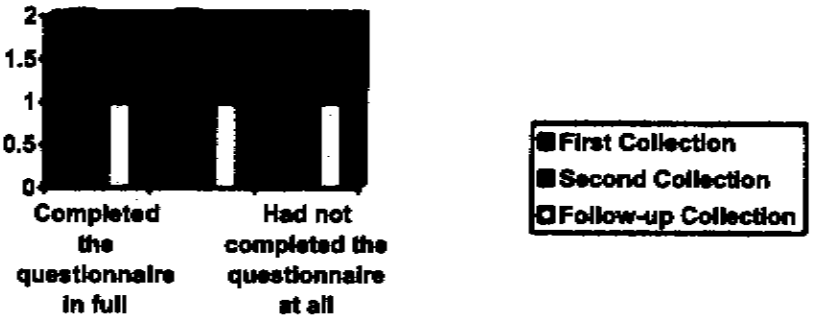
2.4 Piloting the questionnaire

The questionnaire was first administered to ten respondents. It was a self-administered questionnaire where respondents were approached at their home. The pick up date of completed questionnaire was made; two weeks afterwards.

2.4.1 The results of the pilot study

Three respondents could not be reached upon the first collection of the questionnaires, mainly because they were not at home. Four respondents had completed the questionnaire. Two of these respondents who had partly completed the questionnaire had filled in all the health service providers according to conditions. They had not completed or had partially completed the reasons supporting each consultation.

Table 4: The results of the pilot study



Respondents who had not completed the questionnaire in full, but who had fill in all the health service providers reported that they were sometimes unable to explain why they consulted those service providers. This was mainly because it was obvious and sometimes because they did not know how to put it in words. Respondents who had not completed the questionnaire maintained that they did so because they had forgotten about the questionnaire altogether and because they did not find time to complete it.

2.4.2 Implications of the pilot study: Adjustments

Follow-up on respondents who were not at home upon collection were eventually made. All the questionnaires were retrieved. The pilot study showed that familiarity with pen and paper task is a factor confounded with the level of education in as far as completing the

questionnaire was concerned. A respondent that completed the questionnaire and those who had completed it partially were of a higher level of education than those who had not.

Differences in reasons provided for consulting health service providers were also along the same lines. For example: 'Because it is a physical disease'; 'the condition is cultural', contrasted with: 'you have to ... otherwise you are going to die' or 'Doctors cannot see this condition.' For some respondents there were linguistic problems that warranted a more 'township' lingo than a more 'textbook' attempt to explain the condition and sometimes criteria. The reasons for an ability to complete the questionnaire were largely because it was perceived to be long.

Several benefits resulted from changing the administration procedure, i.e. the questionnaire was administered by the researcher (Statistics Canada; 2004); an interviewer administered questionnaire (Wikipedia, 2004).

1. The researcher could establish personal relationship with the respondents, enriching the process. It gave the researcher a greater control over the environment (Wikipedia, 2004). Invitations to focus groups could be addressed to individuals.
2. There were fewer inappropriate responses, the researcher could probe for reasons and record them uniformly.
3. There were no incomplete responses; and the completion time although not necessarily shorter (35-45 minutes), improved.
4. The consent could be acquired and the questionnaire was administered on the spot, saving collection time.

5. Language and education barriers could be bridged, by using alternative terms for conditions in different Black languages. The respondent did not have to write; and the administration was a structured interview format.

2.5 Focus groups

To explore levels of consensus on this topic (Morgan & Kreuger, 1993, cited in Gibbs, 1997), several individuals (17) consented to participate in two one-hour focus group discussions. Focus groups discussions focus on one particular topic (Frey & Fontana, 1993; cited in Catterall & Maclaran 1997), i.e. why are particular health service providers consulted for particular conditions?

2.5.1 Conducting a focus group

Focus group discussions were conducted over the weekend at the researcher's home. Facilitation encouraged dialogue in a permissive, warm and non-judgmental atmosphere. Ground rules were stipulated. These ensured the confidentiality of the discussions. They also ensured that individual views are heard and contested in a respectful way.

2.5.2 Video-recording and transcriptions

Focus group discussions were video-recorded. These video-recordings were transcribed.

2.6 Data Analysis

Frequency tables were constructed. These tables reflected the number of respondents who chose a particular health service provider according to 28 conditions. These tables were constructed according to categories of conditions.

2.6.1 The memo

To assist analysis, a memo was adopted from Wilson (1995, cited in Catterall & Maclaran, 1997). The memo isolated and contextualised inputs of individual participant in discussions. A memo relates individual inputs to the context of the discussions as, objections, support, inquiry, etc. It facilitates the interpretation of the process, i.e. helps the interpretation of defences or change of opinions within the overall context of the group discussion.

2.6.2 Content Analysis

Content analysis is broadly understood as searches for patterns in generality (Mutschin (1998; Stemler, 2001). With regard to the analysis of focus group material, the focus should on the cracking of the cultural code (Chandler & Owen, 1989; Valentine & Evans, 1993; cited in Catterall & Maclaran, 1997). In content analysis, there would also be a need to determine from which the part of the communication inferences that shall be made, i.e. experiences, opinions and feelings (Mayring, 2000). This was followed by a step-by-step procedure, where the material is devised into content analytic units.

2.6.2.1 Conceptual analysis

Conceptual analysis established the existence and frequency of concepts (CSU, 2003). The assumption is that words that are mentioned most often are the words that reflect the greatest concerns (Stemler, 2001). It began with coding for these words. Categories were constructed by coding for words similar in meaning and connotation (Weber, 1980; cited in Stemler, 2001). Through selective reduction, codes were grouped into categories and subcategories of co-occurring concepts; i.e. codes were selected into content categories. Content categories are based on the research questions. A conceptual matrix was created by exploring the

relationship between concepts identified that might suggest a certain overall meaning (CSU, 2003)

2.7 Validity and reliability

Triangulation as a research technique refers to multiple sources of information, where multiple sources of data, methods, investigators, or theories are used (Stemler, 2001, citing Erlandson, Harris, Skipper, & Allen, 1993). In this research study multiple sources of data were used. Transcripts complemented reasons reported for particular consultations in questionnaires. Analysis was informed by patterns from health service providers in observations. Results are further compared with other studies a (Mayring, 2000); a form of triangulation where the intersubjectivity of the experience is related to research studies in similar contexts. Good (2000) asserts that the social constructions of meanings and sensitivity to contextual factors of the research study as frames of individual-community dynamics, social and cultural aspects would be crucial in studying dense and particular realities of multicultural communities (Good, 2002).

2.8 Interpretation and analysis

The reality of these communities cannot be understood from a 'value-free' and objective stance, but from a descriptive-inductive perspective (Gaye, 2002). Linearity of descriptions (Smail, 2002) and concerns with generalisability of findings are framed as concerns with social control. Critical psychology problematizes reductionism (Jaye, 2002; Smail, 2002; Bates, 1999). An analytic process involved the description and interpreting meanings, values and experiences, options and behaviours of this community (Jaye, 2002).

3. Conclusion

This survey is a descriptive study of choices of health service provider by this community. Consulting behaviour was assessed in a questionnaire and two focus groups. Accounts for consulting behaviour were understood as concepts underlying consulting. Reasons provided for consulting particular health service providers were given in questionnaires and transcripts and by tracing individual contribution in transcripts.

Chapter 4: Results

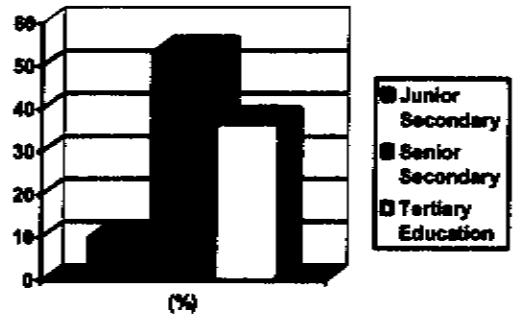
1. Introduction

This research study is mainly descriptive. Results present demographical data of the sample, i.e. age, gender, educational level and annual income. Choices of health service providers are presented according to predetermined categories of conditions. Reasons for consulting health service provider according to one condition in that category will be presented, viz. general medical, psychiatric and culture-bound psychiatric conditions. Conditions where several health service providers were selected is presented to highlight multiple consultation and to show the role of self-help medicine. One condition is selected to represent reasons for consulting for that category of conditions. A concept matrix is used to present salient themes. Individual orientation was assessed using a memo. These techniques were drawn from focus group data representing methods and conceptual analysis (Krippendorf, 1974; cited in MacLaran & Catterall, 1998; Morgan & Kreuger, 1998).

2. Demographical data

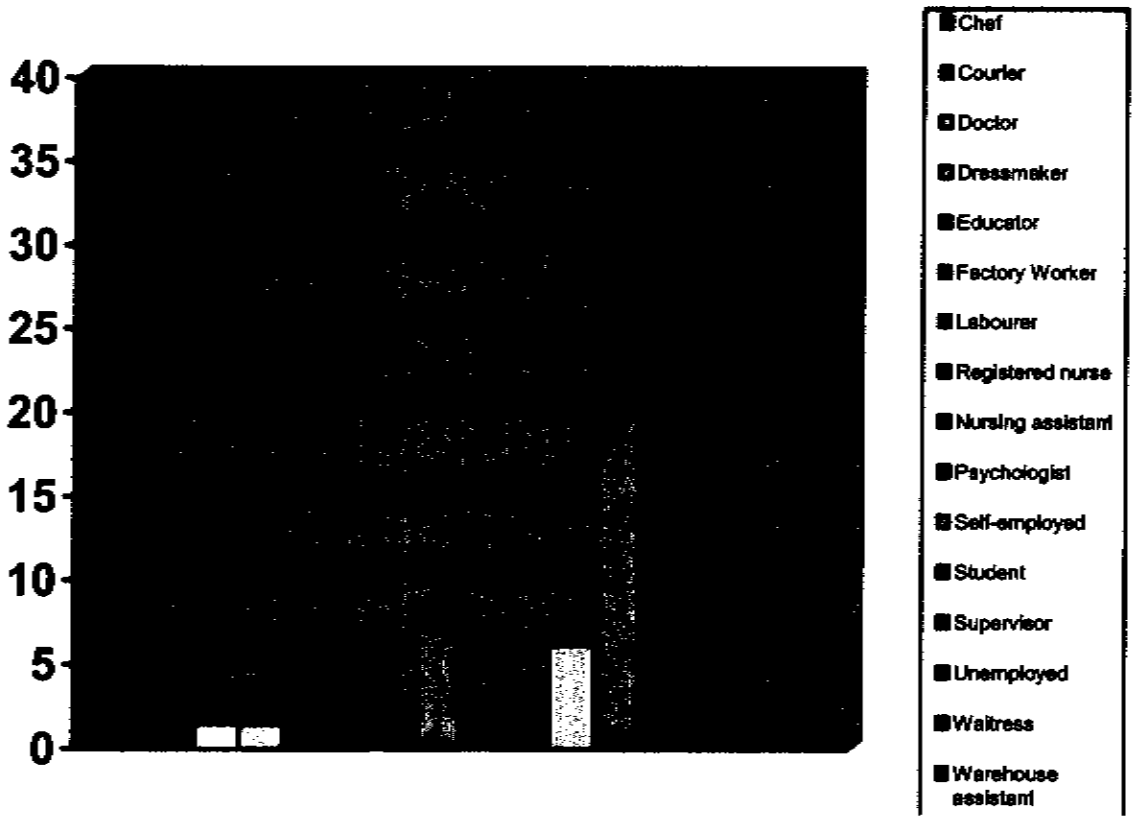
The average age of this sample was 27.95 years of age. The oldest respondent was 50 and the youngest was 14. There were 31 males and 29 females that responded to the questionnaire.10% of the respondents (n=6) reported to have completed standard 8 and below. 53.3% reported to have done standard 9 and 10. 36.7 of respondents reported to have a post-matric education.

Table 5: Level of education (%); (n=60)



With regard to employment, 35.4% of the respondents were unemployed. 20% were students. 6.2% was self-employed. 20% of the members were employed in both manual and professional work.

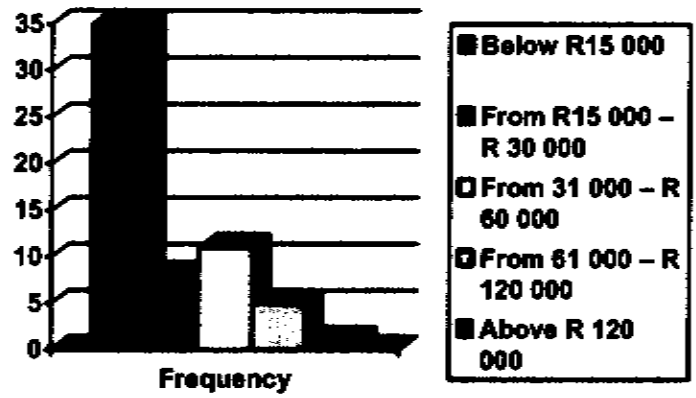
Table 6: Employment; n=60



Of the 58.8% of the respondents who reported to be paid below R15 000 a year are students (30%) and the unemployed (35.4%). 12.5% of the respondents was paid between a minimum

income wage a year (R31 000 – 60 000). 26.7% of this is sample is paid in next three consecutive upper notches of salaries a year.

Table 7: Annual Income, n=60



3. Patterns in consulting behaviour

Consulting patters were derived from a frequency count of respondents who chose that health service provider. These patterns are presented according to categories of conditions, i.e. general medical, psychiatric and culture-bound psychiatric

3.1 General medical conditions

Medical doctors, hospitals and clinics are the treatment of choice for this community in as far as 'physical' conditions were concerned. An average of 67% of respondents reported to consult medical doctors for the treatment of physical conditions. These are conditions reported in a nutshell 'where one goes to the medical doctor for medication or for a toothache'. Injection and pills were perceived as the dominant and expected treatment for these conditions. Over-the-counter medication and traditional herbs and remedies play an important role.

An average of 67% of the respondents would choose mainstream health care services for general medical conditions. Medical doctors were perceived to have the know-how on treating conditions that involved the human body, and their treatment. Injection and pills are expected treatment procedures, with hospitalisation an alternative. General medical conditions are also treatable at home and using over the counter medication, for example ENO for constipation; cough mixture; or even Coke for diarrhoea. For traditionally oriented people, self-help medicine can be drawn from traditional healing herbs that are commonly known or can be sought from *inyanga* who may double up as an herbalist. There is *muthi* in powder form that one would sniff at in case of headaches, enema and a warm bath or steaming 'curing' a wide range of 'common cold' conditions. Family members and friends counsel on correct procedures and may know how to treat a variety of these conditions.

Table 8: Choices of health service providers on general medical conditions (%), n=60

	Social Worker	Medical Doctor	Psychologist	Psychiatrist	Family and friends	*Isangoma*	*Inyanga*	*Umthandazi*	Priest	Other
Headache		83			3		8	3	2	
Childbirth		72		1	3					14
Cold Flu		85			2		2		2	10
Diarrhoea		77		2	1		2	2	2	17
Body Aches		55	3	5	3		10		2	20
HIV/AIDS	8	63	5		7		10		1	10
Cancer		90		2			2		2	5
Inyoni	2	12				10	2	5	2	5
Vomiting		60			7	2	20		5	2
Constipation		62			8		5		2	23
Gonorrhoea		77					15		2	7
STI		62				8	5		2	23

Though the general feel is that medical doctors do well in treating this category of conditions for HIV/AIDS, *inyoni*, and body aches; there seems multiple consultations, that seeming vary

according to different individuals. Attributing underlying causes of body aches to psychological reasons (8%) would warrant that for some respondents consulting psychological services, i.e. the psychiatrist (5%) and psychologist (3%). In accepting death as a result of these conditions priests, family members can also be consulted.

Table 9: Health service providers and reasons provided for consulting them wit regard to cancer

- Other – hospital – for an operation, it needs to be removed before it spreads (*umhlaza*)
- Medical doctor – It is an internal sore (*isilonda*) that would need proper medication
- Priest – by Jesus' stripes we were healed
- Medical doctor – he examines what kind of cancer you are having and provide medication
- Medical doctor – they can do operation and remove the trauma
- Medical doctor – he will give me the pills and injection
- Medical doctor/*Inyanga* – depends on the cause, for traditional people, *inyanga* would be fine
- Medical doctor – to isolate carcinogenous cells
- Medical doctor/psychologist/attorney/ other (self-help) – 1, for treatment and follow-up test, 3&4 someone to talk to if you need to, 4 attorney bank – for your will
- Medical doctor – they will direct you for treatment
- Medical doctor – they know about internal organs
- Medical doctor – chemotherapy and counselling
- Medical doctor – they are well educated about medicine so they can give me medicine for it
- Medical doctor – so s/he can examine
- Medical doctor – they have ways to treat this illness
- Medical doctor – to get medicine; injection and pills
- Medical doctor – there is no medication for this but they can give you medication to calm it down
- Medical doctor – he will check where the disease is and will give you appropriate help
- Medical doctor – will diagnose the virus and then operate on you
- Medical doctor – they are the only one who know about this virus
- Medical doctor – knows his job so he can do the operation safely
- Medical doctor – to find medicine to cure because no one knows how to treat this
- Medical doctor – can remove it and prevent it from spreading
- Medical doctor – can help where you have a problem
- Medical doctor – because I do not know any *inyanga* who know how to treat this disease
- Medical doctor – they studied about it
- Medical doctor – only western medicine can cure this
- Medical doctor – physical condition
- Medical doctor – some are curable, and that has been proven, those cancers that aren't are kept less active, if not, patient quality of life is improved if not so – 'pain free' death in his last days
- Medical doctor – they can do operation and remove the trauma
- Medical doctor – understand the techniques of fixing cancer, he knows about histology and physiology
- Medical doctor – only the doctors can identify and treat cancer
- Other (hospital) – to get good treatment and medication
- Medical doctor – person suffering from *umdlavuza* will need the services of the medical doctor
- Medical doctor – examine my chest and my throat and give me medicine and pills
- Medical doctor – examine how it is going through an X-ray and telling me what is right to eat and to drink
- Medical doctor – he is the only one who can see through my chest
- Medical doctor – so that they will remove the part which is affected and give me proper treatment

Attributing traditional beliefs and religion to some of these conditions, for example, as in a case of *inyoni*; traditional healers would also be consulted. There are individual who see suffering as a sign of parting ways with God, and therefore a priest or a prayer would help alleviate these conditions for these people.

3.2 Psychiatric conditions

These were conditions that understood in a 'universal' sense of the mental illness (Bodibe, 1995; Stricklin, 1990). These conditions loosely pointed towards mental illness, derangement and psychological pain by both western and traditional nosologies. These conditions are consulted for among traditional and mainstream health care services. Social workers, psychiatrist and psychologist were predominantly reported to be consulted for psychiatric conditions. The perceived cause of the conditions can be associated with who is consulted between mainstream and health care providers.

Table 10: Choices of health service providers on psychiatric conditions (%), n=60

	Social Worker	Medical Doctor	Psychologist	Psychiatrist	Family and friends	*Isangoma*	*Inyanga*	*Umthandazi*	Priest	Other
Ukuphambanelwa ikhanda ('crazy')		**13**	**12**	**43**	**3**	**8**	**17**	**2**	**2**	
Uphatheke kabi (depression)	**35**	**3**	**15**	**3**	**35**	**2**	**2**		**5**	
Ufuna ukuzibulala (suicide ideation)	**12**		**53**			**12**			**10**	**3**
Umsangano (mad)	**3**	**3**	**13**	**47**	**7**	**2**	**15**	**5**	**5**	**3**
Uvalo (anxiety)	**3**	**5**	**14**	**7**	**12**	**14**	**12**	**17**	**9**	**9**
Ukuthuka (panic attacks)	**3**	**8**	**7**	**3**	**7**	**15**	**20**	**20**	**3**	**13**

Psychiatrists were perceived as best equipped to deal with the 'head' problems and madness. 43% and 47% of the respondents chose the psychiatrist for the treatment of madness and

being 'crazy.' The 'talking' is acknowledged as mainly dispensed by the social worker professionally, but that the friends and family members would help with regard to depression. Psychologists were seen to deal best with suicide ideation. . Attributing causes of these conditions to evil, either through sinning, sorcery or coming across hazards in the environment; traditional healers would be consulted.

Table 11: Health service providers consulted and reasons provided for consulting for *umsangano*/'Madness'

- Psychiatrist – for observation, maybe the person is lonely
- Psychiatrist – this is a mental institution case
- Priest – because madness is from the Devil, when God created man he didn't have diseases in mind
- Psychiatrist – he can take you to the hospital for further treatment
- Psychiatrist – he can tell me what is wrong
- *Isangoma* – they will burn *umuthi* for me to smoke
- *Inyanga*/Medical doctor – depends on who fixes it – but there are alternatives, even astrology, it depends on our beliefs
- *Inyanga* – the patient might think he has been bewitched and medical doctors have no clue what the treatment would be
- *Inyanga* – if you really believe in this, he will take it out
- Psychiatrist – deal with the brain stuff
- Friends and family – for proper referral
- Psychiatrist – to monitor conditions
- *Umthandazi* – because they able to see things and can help you on it
- Psychiatrist – he/she can take you to hospital
- Social worker – to help you to solve your problem that's make you sick
- Psychiatrist – so that he can check your condition and try to find where the real problem is
- Priest – he will pray for you and give holy water
- Psychiatrist – because he knows how to cure this illness.
- Psychologist – they know about the brain.
- *Inyanga* – they know the herbs used so the can cure
- Psychiatrist – will check the brain
- *Inyanga* – to give you proper medication *uphalaze*/vomit; to get rid of *muthi* from the chest
- Psychiatrist – to be checked and maybe they will find the problem
- Psychologist – to check the cause and find out if there is any hope for treatment
- Psychologist - he knows about people's mind
- Psychiatrist – for treatment like injection and tablets
- Friends and family members – they know me when I am OK and when I am not – they will provide proper referral
- Psychiatrist – to examine my head there might be something wrong with me
- Medical doctor – because he or she is trained in this field
- Psychiatrist – this is definitely a psychiatrist field
- *Umthandazi* – to give you *isiwasho*
- *Inyanga* – can heal you, he will give you herbs to sniff
- Psychiatrist – treats inappropriate behaviour, control and remove identifiable cause, e.g. with drugs for infections and can also help integrate to the society
- *Inyanga* – they can give you something to smoke in your nose and madness might be healed
- Psychiatrist/psychologist and *isangoma* – can be cured and best explained by all

Muthi acquired from either *inyanga* or *isangoma* can be used to deal with a range of these conditions. A *muthi* to sniff in case of madness can be acquired from *inyanga* and *isangoma*. An appropriate cleansing ritual may be suggested. Divination would also be appropriate in order to understand why these conditions happened and who or what is responsible for causing this suffering. A traditional oriented person may choose a *sangoma* for these conditions, whereas a Zionist for example would prefer *umprofithi*. Some Christians believe that suffering is a result of not doing right and is understood by God and it would be appropriate to talk to him for guidance and healing.

With regard to mental patients who are considered dangerous to the community, institutionalisation was seen as appropriate. Several names of mentally ill individuals that respondents knew from the township were mentioned.

3.3 Culture-bound conditions

Conditions whose causes were attributed to *ukufa kwabantu* were the domain of the traditional healers; mainly *inyanga* and *isangoma*. Respondents who considered the 'physicality' of a condition *idliso* with large prospects that it might be tuberculosis would want to consult the doctor. For this conditions doctors are argued to mistaken its symptoms for symptoms of tuberculosis; and that magical forces behind it and the control of the sorcerer over the conditions makes it uniquely treatable by traditional healers who will 'take it out' from the inside.

Idliso, *ibulawo* and *umeqo* are conditions associated with the work of evil, or an evil eye; witchcraft and sorcery. Cleansing with *muthi* and sometimes cleansing rituals can be suggested as treatment procedures. The use of seawater seems prominent in both traditional

and religious people as preventative measures/rituals against evil attack. *Izintambo*; topical incisions, enema, and vomiting can be some of the treatment procedure that are expected, and that can be carried out by the patient at home.

Table 12: Consulting patterns in culture-bound psychiatric; contrasting the mainstream and traditional healers (%), n = 60

	Social Worker	Medical Doctor	Psychologist	Psychiatrist	*Isangoma*	*Inyanga*	*Umthandazi*
Ufufunyane		3	3	5	3	57	12
Ukuthwasa				2	78	15	6
Idliso		12			3	77	7
Ibulawo			3		25	59	7
Umhayizo	1	5	2	10	13	38	11
Umeqo		3		1	21	67	5
Ukudlula	7		5		20	36	8
Umnyama			1		20	55	17
Ibhadi			1		21	43	10

Treatment procedures for these conditions may be similar to the treatment of *ukudlula*; *umnyama*; and *ibhadi*. They would all require cleansing; using either *muthi* or *isiwasho*. A ritual may be necessary to undo a result of engaging in behaviour that is considered taboo. The difference between the use of *muthi* and *siwasho* is also highlighted. There is a need for divination to understand why a problem occurred for both. A *muthi* or more traditionally oriented person may prefer a *sangoma* as opposed to *siwasho* person who would consult an *umthandazi*. Respondents who consider *idliso* to be similar to tuberculosis would consult a medical doctor. There were emotional, physical and social attributions to causes of these conditions.

Table 13: Health service providers consulted and reasons provided for consulting for *ukuthwasa*

- *Inyanga* - so that he can be initiated to be a healer (*idlozi*)
- *Inyanga* - he will initiate a person to be an *inyanga*
- *Isangoma* - because *ukuthwasa* is a spirit of false prophets like *isangoma*
- *Umthandazi* - to pray for the demon to go away from me
- *Isangoma* - they know how to do the *ukuthwasa* rituals
- *Inyanga* - they know these things about *ukuthwasa*
- *Isangoma* - it is cultural ; people will always have to go to *izangoma* and it was there before we were there
- *Isangoma* - because *isangoma* can communicate with the ancestors
- *Isangoma* - *ukuthwasa* is an *isangoma* speciality – a person can *thwasa* to become an *isangoma*
- *Isangoma* - it is a traditional process of entering the spirit world
- *Isangoma* - must be seen by *isangoma* for divination to know why and will heal from that
- *Isangoma* - *Isangoma siyathwasisa*
- *Isangoma* - because *sangoma's* knows what is needed about *ukuthwasa*
- *Isangoma* - they know well about medicine and treatment
- *Isangoma* - *izangoma* are able to do the initiations rituals for one to quality as *isangomas*
- *Isangoma* – people who are [*ukuthwasa*] are going to be a sangoma they can be helped
- *Isangoma* – it is their job [*ukuthwasisa*] they understand it much
- *Isangoma* – because it is their jobs
- *Isangoma* – it is *isangoma* who knows how thy do *ukuthwasa*
- *Isangoma* – it is training for traditional healers.
- *Isangoma* – because you start *ekuthwaseni* to be a *sangoma*
- *Isangoma* – it is their job
- *Isangoma*- it is only *sangomas* who went through this experience
- *Isangoma* – they the older people [*amandlozi*] to do their job by you
- *Inyanga* – to open it for further training and to become an initiate [expensive]
- *Isangoma* – was also initiated, s/he will know how to initiate you.
- *Isangoma* – when ancestors decide to call you to work for them you must be initiated
- *Isangoma* – they age called by the ancestors
- *Inyanga* – it's the person who can train me to be like he is.
- *Isangoma* – to give me an idea as to what to do with this person
- *Isangoma* – she will know what is right for me to do
- *Isangoma* – they know very well about traditional medicine and treatment
- *Isangoma* – can teach you how to speak to the ancestors
- *Isangoma* – can help when a person needs to be initiated
- *Isangoma* – because that is the only one who can help
- *Isangoma* – because you have to *thwasa* first to be a *sangoma*
- *Isangoma* – because it is a traditional thing
- *Isangoma* – *isintu* – traditional people that this
- *Isangoma* – *izangoma* themselves go through this ritual, so they will know what to do
- *Isangoma* – because they always do *ukuthwasa* before they become *isangoma*
- *Isangoma* – they know what *ukuthwasa* is, they went through it before they became *izangoma*
- *Isangoma* – culturally related, they need someone who knows something about culture

3.4 Self-help medication and concurrent consultations

HIV/AIDS, body aches, *umhayizo* (hysteria), *inyoni*, and a number of psychiatric conditions show a diverse spread among both traditional and mainstream health care providers. There is a use of both methods, either consecutively.

Table 15: Health service providers and reasons provided for consulting for HIV diagnosis and treatment

- *Inyanga* /Medical doctor /*Umthandazi* – they will all treat it accordingly, a person needs all of them
- *Inyanga* /Medical doctor – to try traditional medicine and then later the hospital
- Priest – I have read many testimonies about the people who had HIV who are now healed
- Medical doctor/Social worker– they work hand in hand, together helping you to forget about the virus to live as normal a human being as possible
- Medical doctor/*Isangoma* – this sickness is not curable so they can both try to heal it
- Medical doctor – may he can heal
- Medical doctor – for treatment with Nevirapine although I am not sure if it works or not
- Medical doctor/psychologist – to get antibiotics to boost immune system, to a psychologist to help cope with the condition and to a dietician for the selection of proper food.
- Medical doctor/friends and family members/psychologist/other (self-help) – 1, to confirm test and make follow-up for medication, 2&3 counselling, if you want to talk about it, 4 draw up a will if you do not have one already
- Medical doctor – so that the doctors ca help you with medication like tablets
- Medical doctor – they will give you a proper medication
- Medical doctor ;psychologist ; friends and family – 1st treatment 2nd counselling and for a support
- Social worker– they can advice me on what to do after finding out that I am HIV positive
- Medical doctor – so he can take some blood
- Medical doctor – Anti-viral drug medication
- Social worker – to give you a way to make a better life helped by your family
- Medical doctor – because there is no other person that knows how to heal it
- Social worker – they will tell you things to do and take care of yourself
- Friends and Family Members – they will take care of you so that you can acquire other decease.
- Medical doctor – they are taught about these diseases.
- Social worker – to give the advice on how to go on with your life
- Medical doctor – but there is no treatment to heal this disease
- Other – cannot be cured, you take care of yourself among family and society at large
- Medical doctor – it's a disease that needs real care to the patient and there is still no cure for it
- Medical doctor – because it is easy to be effected with other diseases
- *Inyanga* – they have remedies to get you to eat if when you have lost appetite and they also help you give remedies to dry you out when you have diarrhoea
- Psychologist /social worker – to give him counselling and help the person accept his or her predicament
- Medical doctor then a psychologist – physical condition that might have emotional implications
- Medical doctor then a psychologist – medical doctor will help with opportunistic diseases and latest drugs if they are affordable and one will get emotional support from the psychologist
- Medical doctor – they try to give treatment to help fight the virus
- Medical doctor/*inyanga* then a social worker – it Is a process you have to go through all of them
- Medical doctor – he can identify the virus in the blood
- Medical doctor – you have to go to the doctor to check your blood
- *Inyanga* – have medication for *ingculaza*; like *unwele* (African potato)
- Medical doctor – because they are still testing herbs to find the cure
- Friends and family members – To give me support and tender care

There are self-medicating procedures that in themselves are using a diverse source of healing procedures. The use of traditional medicine that respondents know themselves, the over-the-counter medication and consulting more than one health care provider; mode of healing were an intriguing efforts in the a complex use of biomedical and traditional healing methods. The use of Med-lemon; some Dutch remedies; ENO is preferred but when the conditions

worsens; one would consult a doctor. The use of Med-Lemon does not preclude the need to vomit the following day because a person might be suffering from '*inyongo.*' The use of *muthi* can be by brewing concoctions that are a common knowledge within the people; but that may have been suggested by the health service provider. The use of family and friends as resources for appropriate health care is important

4. Conceptual analysis

Central to understanding activities involved in choosing which healing method to use among the focus group participants is a prevalent belief in supernatural forces. These forces are magical and are tied to the African cosmology. Traditional healers are able to 'see' some conditions. This is a reference a correct diagnosis as well as divination. Bad spirits can be very instrumental in creating disease. Evildoers and sorcerers may account for suffering, but that a person can come across environmental hazards, e.g. in a case of '*habula.*' It may necessary to 'strengthen' oneself especially the household and other belongings. The understanding of conditions can be exclusively within traditional healers.

Among the participants, there was a tendency to homogenize healing rituals across cultures. Particularities were perceived as varieties of same rituals; a perception of universalities in healing. Traditional healing methods are perceived as particular to *abantu* but that healing in general is attributed to getting better; alleviating the condition; removing an illness, etc. There is also awareness that with time healing methods and their use may change.

Medical doctors are perceived to be at the centre of western health care. Although medical doctors are seen to be limited with regard to treating traditional conditions, they are seen to be well resourced in the treatment of physical conditions.

Table 16: Conceptual matrix

Supernatural	See	**Cannot see it; 'propheted'; not been helpful; foresee; *ukubona*; *umprofithi*; *isangoma*; will check you**
	Spirits	***Umoya omubi*; pollute; bad; *habula*; raise; good; all over the place; bad; *incweba*; bad spirits**
	Protect	**Take care of you; strengthen; guard you; sinking skull**
	Place	**Home; own place; lie; household; doorstep; where; relatives; stepped; employers**
	Magical	**Run away; *izinto zabantu*; control; follow-up; ritual; custom; function; slaughter; culture; sorcery; swelling foot; sent through; sorcerer; bewitch; the air; traditional; traditional healers/working people (*abantu abasebenzayo*); healer; live with; *abantu*; way of life; witchdoctor; *isangoma*; customs; hide (*isikhumba*); *incweba*; *muthi*; *amagqira*; *amaxhwele*; ancestors**
Hospital	Hospital	**Natalspruit; Clinix™; Union™; card (medical aid card); bed; care; good care**
	Doctor	**Qualified; hold it; VD; TB; HIV/AIDS; body; medicine; VD; X-ray**
Ill-health	Condition	***Ukufa*; trouble; ailment; problem; consult; see; send**
	Sleep	**Bed; suffer; kill; dead; death**
	Help	**Alleviate; sort out; cured; ill; medicine; remove; go (attend); consult; better; check you; heal; work; working; vomit; straighten you up; job; *imbiza*; better; treatment**
Tradition	Customs	**Same; different; person; white man; white; human; human race**
	We	**Blacks; Darkies; True medicine; *abantu***
	Now	**Today; ago; life; long way**
	Belief	**Believe; differentiate; white; God; pray**
Expenses	**Pocket**	**How much; credit; money; afford; cash; pay; charge; cost; R70, 00; R13; 00; R25, 00; R5, 00; expenses; expensive; spending; livestock; free**

Mainstream health care was perceived according to affordability, where a local hospital, Natalspruit was perceived to be less capable of 'good care' when compared to Clinix™, Union™; and other private hospitals. While in mainstream health care expenses are associated with good care; it is not necessarily true that traditional healers are cheaper. Expenses on logistics behind consulting a traditional healer and preferably a distant one would be as costly, so are the payments for traditional healers to 'work' on the household to perform 'preventative' rituals, for example. Family and friends, priests are helpful agencies that are cheaper and free; but that there is usually a consultation fee with the prophet, who is usually R5, 00.

5. The memo - individual orientation

With regard to the memo, individual orientations points towards a general acceptance of mainstream health care services. Variety among consultations associated with the belief system stems from orientation towards either traditionality or Christianity. While there is a common belief in the evil out there, there are different approaches as to how the knowing about that evil person; which rituals would be preferred and either to use *muthi* or *siwasho*.

The use of the *siwasho* is associated to the use of *izintambo*; a protective string against evil and bad spirits; and *incweba*; a traditional hide version. The priest and the services of the *umprofithi* may differ in that the prophet may divine, but that most priests would 'counsel.'

5.1 Orientation

The majority of the participants did not particularise any major belief system. Traditional views do not interfere with religious and medical views; and a person can use both the traditional healer and *umprofithi*. There are, however some respondents who would pay

particularities with regard to consulting among traditional healers. For the traditional/medical group; there is no place for a priest or a prophet. Ancestors and the works of the evil eye are central in making sense of healing. Traditional medicine would be preferred and is used frequently. Part of routine would be to engage on preventative measures and balances created by a metaphor for imbalance – *inyongo*. Traditional medicines, enema, vomiting and steaming may form an integral part of this orientation.

On the opposing side would be those who have divorced themselves from using *muthi* altogether and sometimes in preference of *isiwasho*. Healing here is largely defined around religion. Part of the package of doing away with traditional healing involves doing away with ancestors; a very contentious issue. However, part of this portion believes in divination, a fundamental need to answer the question why a condition happened and to seek light and guidance.

Table 17: Orientation

Orientation	Patterns	Number of participants
Traditional/Medical	-Believes in the biomedical approach -Traditional explanation dominant; ancestors and the evil eye are sources of ill-health -Would prioritise the use traditional herbs and *muthi* -A prophet or a priest would be used only just	3
Traditional/Medical /Religious	-Would use mainstream health care services -Would attend traditional healers and may use *muthi* -May go to church and is open to the prophet and the use of *siwasho*	7
Medical/Traditional	-Biomedical explanation predominates -Some conditions are perceived as traditional, but some conditions are emotional and psychological -Church may also play a crucial role	3
Religious/Medical/ Traditional	-Relies on mainstream health care -Would prioritise the use of prayer and *isiwasho* and may prefer the priest or the local prophet -*Muthi* use may be shunned away from; or may not be admitted	4

Table 18: Memo – Participant number 4 – (P4)

P4 -Sometimes when a person gives you *idliso*, they do not want to kill you. They want you to suffer such that even when you go to medical doctors they won't see it. They do this so that you suffer and lie in bed for a long time. They want to see you in bed. This person is saying, "I want to see Thabile suffering".

HELPING ANOTHER PARTICIPANT EXPLAN *IDLISO* AS THE WORK OF THE EVIL EYE OR PERSON THAT WOULD CONTROL AND OPERATE IT MAGICALLY

P4 -As momma was saying that the western doctor must work together with the traditional doctor because the medical doctor can hold *idliso*, but he can see that the traditional doctor can heal it. Then the traditional doctor will decide as to whether to give the person something to use to vomit, enema (*imbiza*), and has to use if four times a week. The medical doctor will give him pills and medication to treat it.

SUPPORTING A BIMODAL APPROACH TO HEALING WITH REGARD TO THE CONDITION *IDLISO*, SHE IS SUGGESTING A COMPLEMENTARY ROLE MAINSTREAM AND TRADITIONAL HEALTH CARE SERVICES CAN PLAY

P4 -Listen...right…In this issue of religion…let me say you are ill … you have the headache and as momma was saying you are not a *muthi* person; you are a religious person. So, you go to the priest to tell him that you can't sleep and you have tried medical doctors. The priest will not say to you – 'I am curing you' or 'I am healing you'. He is a priest … he will just pray for you. You might even notice that you are feeling better after Pastor Matheza or Pastor Mavhungo has prayed for you.

RESPONDENT DIFFERENTIATES BETWEEN A 'MUTHI' PERSON AND A 'SIWASHO' PERSON. THE LATTER HAS DIVORCED HERSELF FROM THE USE OF MUTHI AS A RESULT OF AFFILIATING WITH A CHURCH. SHE ACKNOWLEDGES THE NEED FOR THE 'TALKING CURE,' OR PASTORAL COUNSELLING. SEES PRAYER AS IMPORTANT ELEMENT IN HELPING A PERSON FEEL BETTER

P4 -I think *isiwasho* is water. They pray for it and tell you to go and drink it. It's plain water from the tap. It's not water from the sea or something. It is plain water that *umphrofithi* has prayed for.

THE RESPONDENT IS CONFIRMING THE NON-DRUG COMPONENT IN ISIWASHO; AS OPPOSED TO OVER-THE-COUNTER MEDICATION AND THE TRADITIONAL MUTHI. FOR HER, THERE IS POWER IN RELIGION THAT IS IMPORTANT FOR HEALING – ALSO HIGHLIGHTS THE PLACEBO EFFECT IN MEDICATION. SHE IS ALSO ALIGNED WITH THE INDEPENDENT AFRICAN CHURCHES

P4 -It's like …*intambo* is used by prophets. Like in the Zion church…say you have feats or epilepsy. When the prophet prays for you he also tells you what is wrong with you. You understand…

THE RESPONDENT WOULD CONSULT A PROPHET MAINLY FOR DIVINATION AND THE PROPHET WOULD GENERALLY PRESCRIBE A PROTECTIVE MEASURE, INTAMBO. THIS INTAMBO IS WORN AROUND THE WRIST, WAIST AND SOMETIMES BUT RARELY AROUND THE ANKLE. THE UNDERLYING ASSUMPTIONS IS THAT THERE ARE ECOLOGICAL HAZARDS THAT A PERSON NEEDS PROTECTION FROM

P4 -he sees something inside you. You know that different prophets use different colour strings.

When they pray for you they then decide on the colour of the *intambo* to give you and where to put it…either on the wrist, or on the waist or on the ankles… then it will be alright.

RESPOND TO A QUESTION HOW A PROPHET COMES TO DECIDE THE COLOUR AND THE TYPE OF THE STRING TO USE. SHE DESCRIBES HER EXPECTATIONS WHEN CONSULTING WITH A PROPHET

P4 -You know what…

ANOTHER RESPONDENT HAD QUESTIONED THE SOURCE OF THE MESSAGE OF THE PROPHET'S DIVINATION. HIS PREMISE IS THAT THE SOURCE OF DIVINATION FOR TRADITIONAL HEALERS IS ANCESTORS. THEY 'CALL' A SUITABLE CANDIDATE. SO, FOR HIM THE SUGGESTION THAT THE PROPHETS ARE COMMUNICATING WITH GOD IS RIDICULOUS? THIS RESPONDENT TRIES TO INTERJECT.

P4&P9 -My brother …

SHE COLLABORATED WITH ANOTHER ADULT MALE TO INTERJECT EVEN FURTHER IN AN EFFORT TO 'CORRECT' THE MORE TRADITIONALLY ORIENTED RESPONDENT ON THE USE AND THE BASIS OF THE PROPHET'S DIVINATION

P4 -In this issue of sorcery …Sorcery, for me…I do not believe in it. When an *inyanga* tells you that you have been bewitched … there is nothing like that … they just want to steal your money. I want to tell you something. If someone tells you that you have bewitched, they are lying to you. Sorcery for me … when you talk to your heart… when you tighten your heart and say 'I want to see Thabile suffering'. For me all I see is that I wake up everyday to work, and even though all my efforts are fruitless. I do not gain anything. I then tell myself that I am going to consult *inyanga*, who will throw bones and instead of telling me that Bro... So and so...has tightened his heart [against me], he will tell me about Bra Velaphi, and that it's him. It's him, he placed *muthi* at your gate …yet Velaphi is someone who is nice to me and with whom I get along very well. When it comes to prayer and all that…Let's say it is the same as when you go *inyanga* for your *idliso* that you strongly believe that it can be cured by *inyanga*. The issue of sorcery … for me…it is not there.

SHE HAS DIVORCED HERSELF FROM MUTHI USE AND BLIEVES THAT TRADITIONAL HEALERS CANNOT DIVINE WHO BEWITCHED YOU. BASICALY, EVIL A BELIEF IN BEWITCHMENT IS FOR A HOAX. SHE BELIEVES IN THE EVIL EYE AND THAT A PERSON DOES NOT NECESSARY HAS TO ACT ON HER 'BAD HEART.' HAVING A BAD HEART AGAINST SOMEONE IS GOOD ENOUGH AS HAVE DONE SOMETHING LIKE BEWITCHING THE PERSON.

P4 -I am not saying it is not there. We have different religions – Bewitchment is there for you and not for the other person. For me, it is in your heart.

HER POSITION ON SORCERY … SEEMS MORE TOWARDS SIN-RELATED

P4 -I used to go to a doctor who charged me R70.00 for consulting him, but because you don't have money today, you'll have to go to Natalspruit.

PRIVATE DOCTORS ARE MORE EXPENSIVE THAN HOSPITALS

The general choice for mainstream health care services can be associated with an understanding of the logistics behind their organization. This is adherence and priority to the biomedical approach, where other explanations are an exception. There are however some conditions whose conception among this group involves supernatural inferences. For a respondent in a medical profession, for example, *ukuthwasa* is a condition that warrants consulting with traditional healers, but that the medical doctors can help alleviate the symptoms and treat treatable symptoms. It seems there is hardly a divorce from traditional orientation in some conditions and that no conclusive findings can be suggested by a role of education with regard to consulting for culture-bound syndromes.

The memo presented in these findings is of a lady who is on her late twenties and who is coded as oriented towards Traditional/Medical/Religious. She believes that *idliso* operates magically and that it cannot be treated successfully by medical doctors. She herself prefers a priest, divorces herself from *muthi* use. She believes in the work of the evil and describes the sorcery to be from a 'bad' heart of that person.

6. Conclusion

Respondents drew from both mainstream and traditional healing paradigms and the extent may be dependent on the orientation of an individual. Religion was associated with choosing among traditional healers, *isangoma* and *inyanga*; and the prophet. It was proposed that similar archetypes seem to exist between *muthi* use and *siwasho* use. The priest, family and friends play a major role as support structures.

Chapter 5: Discussion

1. Introduction

Results showed that this sample of a Black township community would use both mainstream and traditional health care services. Mainstream health service providers would be consulted predominantly for natural conditions, i.e. 'physical' or medical conditions. Traditional healers would be consulted for conditions attributed to supernatural causes; mainly culture-bound psychiatric conditions. Attributing illness conditions to supernatural and magical causes was prevalent even for members of this community who would prioritise the use of mainstream health care services. Traditionally oriented members of this sample would have medical health care services and practices as part of their treatment plan. This simultaneous use of mainstream and traditional health care systems was associated with an individual's orientation towards modern, traditional, and religious ways.

2. The use of mainstream health care services

Mainstream health care services were reported to be best suited to treat medical or physical conditions. This has been conceived as the acceptance of the biological explanation of illness conditions (Edwards, 1983, Edwards, et. al., 1983, Ngubane, 1977). Ngubane (1977) explained the natural attribution of causes of illness conditions as part of the African cosmology. Han (2001) argued that the level of sophistication is required to fully appreciate mainstream health care services. From this perspective, fluency to modern ways, a certain level of westernisation and even education would be important in how mainstream health care services are utilised.

Even for traditionally oriented people, there is an increasing demand for western health care services (Edwards, et. al., 1983), and western health care practices would form part of their

treatment plan. Ngubane (1977) concluded that the biomedical explanation was compatible with African people's beliefs. The notion of the malfunctioning of the organism (as in a case with hysterical paresis which was explained as resulting from "bad blood"), or natural processes (e.g. ulcers; being regarded as a process of ageing) forms part of the African cosmology (Ngubane, 1977).

For members of this community who prioritised the use of mainstream health care services, Han (2004) associated this pattern in consulting with westernisation. Han (2004) argued that the knowledge of mainstream health care resources is imperative in order to appreciate them. In a study by Stones (1996) educated members of the society were associated with 'enlightened' attitudes about health care professionals. Illness conditions were categorised in terms of physical, emotional and cognitive causes. Stones (1996) associated this distinction with fluency to modern ways, education and social class.

3. The use of traditional methods

Even though there is a high regard for western mental health care in times of distress there is a tendency for Black people to revert to traditional beliefs and practices (Edwards, Cheetham, Majozi and Mkhwanazi, 1983). Modern trained professionals, for example, one medical doctor, two psychologists and five professional nurses that responded to the questionnaire reported that there are conditions that are perceived to be exclusively the domain of the traditional healing. For Cheetham and Griffiths (1982), even when Black patients recognise the value and the efficiency of western therapy, this is often by partial acceptance. For Pretorius, et. al., (1993) as long as traditional beliefs continue to exist, Africans will require traditional medicine in the case of illnesses, which are defined and explained in a personalistic manner.

Ukufa kwabantu conditions were perceived to be exclusively the domain of the traditional healers. However, the use of traditional 'health services' would be non-directional. Traditional oriented people would use it to supplement mainstream health care. In the International Symposium on traditional healing (2000) it was indicated that most traditional oriented people would consider mainstream health care services after the traditional healing methods have not succeeded. It may also be used after mainstream health care services to either treat the 'real' condition; e.g. *idliso*; or to 'complete' the cure; e.g. HIV/AIDS. Cheetham and Griffith (1982) observed that in clinical practice at King Edwards VIII Hospital in Durban; patients attend *isangoma* subsequent to hospital treatment in order to 'complete' the cure. A study in Botswana found an increasing tendency to use modern medicine as a "quick fix" solution. Traditional medicine was utilised for providing answers that may be asked about the meaning of the misfortunes. This way the real illness is dealt with (Steen & Mazonde, cited in MacKian, 2004).

Ukufa kwabantu are conditions that this sample attributed to magico-social and supernatural causes. They are defined as caused by the evil eye, e.g. *idliso*, *umeqo*; by disharmony with ancestors, e.g. *umyama*, or by engaging in acts which are considered taboo, and coming into contact with ecological hazards; e.g. *umyama*, *ukudlula*.

For traditional people, consulting mainstream health care services for physical conditions can be part of this broader plan. For some of these conditions, for example *idliso*; a medical doctor can treat it for a short time – 'can hold it'. There is a perception that medical doctors cannot 'remove it' completely; only an *inyanga* or *isangoma* can. Religious members of this community would consult a prophet who would administer *isiwasho*. This may be

particularly true with those members of this community that present themselves to have dissociated themselves from *muthi* use.

3.1 The belief in supernatural causes of illness conditions

This community would consult traditional healers for conditions perceived to have supernatural causes. Despite the use of mainstream health care services, in 1981 the World Health Organisation stated that it is a fact that the traditional systems of healing remain the major source of mental and physical health care (WHO; cited in Edwards, 1985). A conclusion drawn by several studies (Elliott, 1984; cited in Pretorius, et. al., 1993; Edwards, et. al., 1983) on medical students corroborate that education does not negate attributions of some conditions of suffering to supernatural causes; distraught relationship with ancestors; sorcerers and the evil spirit. Traditional rituals and practices would be carried out to rekindle a good relationship with ancestors and to acquire their favour and protection from evil. The evil may be perpetrated by a sorcerer. Polluted environments and engaging in behaviour considered taboo may also need rituals for cleansing, especially with *muthi*.

3.1.1 The role of the prophet

The role of *umprofithi* was argued to be a compensation for basic traditional archetypes. Religion does not negate the belief in and desire for protection from ecological hazards and the evil eye. The prophet has a role similar to that of *isangoma* in that they usually embrace 'foretelling' abilities *(ukubona)*. They also dispense *isiwasho*. They may work within the traditional churches or may open up private practice and they usually are the cheapest health care. Pretorius, et. al. (1993) attributed this divorce from *muthi* use to religion. Instead of using *incweba*; a traditional hide that is used for protection again ecological hazards and the works of the evil eye, they use *intambo* for the same purposes. Universal healing practices

like dancing (*ukuxhentsa*), beating of drums, singing, etc. would be prevalent; but that are not interpreted, in the light of ancestors (*izinyanya/amadlozi*), as traditional healing would.

For du Toit (1980, cited in Kahn and Kelly 2001), 99% of the nurses reported to be Christians, yet 89% of them reported to practice traditional rituals and customs. This study found that among South African Blacks, neither urban residence nor membership in the Christian church necessarily implies a break with traditional supernatural beliefs or religious and ritual practices. In this study by du Toit, 90% of the urban Blacks were Christian and almost half of them performed traditional rituals and reported that in the time of crisis they consult a traditional healer.

For Edwards et. al. (1982) [South African] Zionism is a syncretic religion in the sense that it embraces levels of both Christianity and traditional 'ancestor worship' (Edwards, et. al., 1982); or more correctly 'ancestor remembrance' (Bührmann, 1984). Zionist possession is ascribed to the presence of the Holy Spirit or '*umoya*' and resembles '*ukuthwasa*' possession in a less strenuous physical and psychological form (Lee, 1969, cited in Edwards, et al., 1982). Zionist possession is often accompanied by belching, 'talking in tongues' and prophetic dreams. The *umthandazi* or faith healer is commonly a full minister in the Zionist church (Edwards et al., 1982).

4. Concurrent use of mainstream and traditional healing methods

For conditions attributed to *ukufa kwabantu* this sample would consult traditional healers. For medical conditions, including some psychiatric conditions, mainstream health service providers would also be consulted. This concurrent use of mainstream and traditional health care services depends mainly on the nature of the conditions. There are diverse varieties in

consulting among service providers that are associated with four overlapping orientations, i.e. in consulting for psychiatric conditions. The use of self-help medication would be used to explore a postmodern trend in consulting both mainstream and traditional health care services that transcends orientation. The tendency to subscribe to disparate health systems, medical dualism, is a notion that both mainstream and health care systems were used.

4.1 Psychiatric conditions

Similarly to consulting for 'physical' conditions; both mainstream and traditional health care services would be consulted for psychiatric conditions. Mainstream health care providers would be consulted for psychiatric conditions, but that for traditional people some of these conditions are a domain of traditional healers. Traditional *ukufa kwabantu* theories especially those explaining madness or *ukuhlanya* are common. Apparently for mental illness, the majority of the African people prefer traditional healing (Stones, 1996). Edwards, et. al. (1985) found that traditional beliefs were mostly held by older, rural people with lower formal education.

Conversely younger, urban and university Blacks with higher formal education favour a more modern bio-psycho-social-cultural aetiology for madness (Edwards, et. al., 1995). There was also, strong beliefs in both ancestors and sorcery in a sample university educate Black people. One reason for the prevalence of such beliefs and practices is that traditional practitioners, who typically diagnose and treat the *ukufa kwabantu* disorders, reinforce them (Edwards, 1985). Cheetham and Griffiths (1982) found that urban and rural patients expressed the desire for the religious or traditional approach to their illness.

4.2 Self-help medication

Mainly to avert minor physical ailments; and more in particular constipation, headaches, diarrhoea and constipation; over the counter medication was reported to be used. There are also traditional ways of dealing with these ailments including enema, vomiting, sniffing, bathing, and steaming. Karlsson and Moloantoa (1984) involving some herbal remedies and infusions that are used as household remedies and are usually common knowledge. Two critical points are made with regard to the use of both medical and the traditional orientation systems. a) Mainstream health care practices form an integral part. b) They depend on the nature of the conditions, but they not preclude or exclude traditional healing – they are non-directional. This medical pluralistic way of engaging health care services was proposed as reflective of how complex and inextricably intertwined the use of both mainstream and traditional ways have been internalised as dominant pattern in seeking health care for these communities.

5 Socio-economic factors

Members of this community associated expenses in the use of mainstream health services with private hospitals. Those in private practice were perceived as more expensive so were those who were regarded as specialists. In a study by Farrand (1984) on healers that are preferred and consulted, twenty-one patients (32%) chose to see the doctor alone. Doctors in private practice were also perceived to be more expensive. In the developing world, the cost of modern medical services may be one important reason for people for turning to traditional remedies and medicine (WHO, 2000).

The WHO also acknowledges that traditional healers vary greatly and fees charge can be high (WHO, 2000). Swartz (1998) reported that the cost of medical care have spiralled over

the years. In a township community of low socio-economic status characterised by a high level of unemployment 35.4%, the tendency to opt for professionalized psychiatric and specialised help for conditions of physical, emotional and cognitive dimension is expected to be minimal. 26.7% of the employed can afford a decent medical aid. The minimum annual pay to qualify for medical is R32 000 (as at 1994; Discovery™ Medical Aid) per annum.

The choice of which *inyanga* to consult would be determined by expenses. Lusu et. al. (2001) found that, while *izangoma* in general are regarded as villains and only a specific [own or distant] *isangoma* is seen as being good. A middle age traditional man confirmed in focus groups that a distant *inyanga* is usually preferred. Travelling costs would also contribute on the choice of traditional healers. In consulting that particular healer would not only affirm a belief by the willingness to pay, but that it can help affirm the belief and consequently help with the condition. In Lusu (2001) those healers working in closer and in industrial areas are viewed with suspicion and described as not giving 'true medicines', only there to 'take your money' and as '*skelms*' (rogues).

6. Pathways to health care

A review on the use of both mainstream and traditional health service providers showed that these healers would be consulted according to the nature of conditions. They may also be used simultaneously for similar conditions, as a quick fix or in order to complete the cure. This sample would consult mainstream health service exclusively for medical conditions. They would also use traditional health care for culture-bound and some psychiatric conditions. For conditions like HIV/AIDS, *idliso*, and some psychiatric conditions; there is a tendency to use both health care services simultaneously. From this view, both health care services would feature in a typical health care plan; irrespective of individual orientation.

7. Conclusion

This chapter discussed the use of mainstream health care services, both as a medical hegemony and as the acceptance of the psychophysiologic approach to health and healing. The use of traditional health care system was attributed to the prevalence of the belief in supernatural causes of illness conditions. For traditional oriented people mainstream health care may supplement traditional ways. But that mainstream health care practices would be an integral part of their treatment plan. Religion was associated with the choices this sample made with regard to traditional healers. Particular attention was paid to the use of both mainstream and health care services as reflecting an eclectic approach to health and healing.

Chapter 6: Conclusion

1. Introduction

Choices of health service providers by a Black township community showed a pluralistic approach to health and healing. The use of both mainstream and traditional health service providers was integral in the health care plan for both modern and traditional members of this sample. The concept of medical pluralism has been proposed in social sciences to illustrate a health care plan that entails the use of mainstream and 'alternative' health systems (Lewis-Fernandez & Kleinman, 1995; Scanlan, 1998; Kaptchuk & Eisenberg, 2001; Han, 2001). Although 'alternative' would be a misnomer, not in this country only but all over the world, it denoted that communities may prioritise one health system, and may use the other to supplement the dominant one. There are conditions that particular health service providers would exclusively be consulted for. Nevertheless, a broader health care plan would involve consulting both; to either supplement or to 'complete' the cure.

Medical pluralism as a phenomenon has been noted to be more of a rule than an exception in this country (Swartz, 1998) and in similar situations around the world, including ethnic minorities in developed countries (Good, et, al., 2001). As a recommendation with regard to the provision of mental health services particularly to reflexive communities (MacKian, 2003), this chapter discusses treatment packages (Katz & Wexler, 1995; cited in Ebigbo, 1996). They involve a long overdue integration with the informal health sector, which the government has suspended pending more research studies. Recommendations with regard to future research studies are discussed followed by the strengths and the limitations of this study.

2. Medical pluralism and reflexive communities

Prevalence of medical pluralism has been presented in treatment plans that collectively engage both mainstream and traditional health systems. Good (1977, cited by Fako, 1989) reported that the world's population continued to use indigenous health services and practices even where there are modern health facilities. In Kwa-Zulu/Natal the majority of the children who had attended hospitals and clinics had first received traditional medicine (Lusu, Buhlungu & Grant, 2001). According to Holdstock (1979, cited in Stones, 1996), the majority of African people prefer to consult traditional healers and according to Bodibe (1995), such a consultation is sought whatever effort or cost it takes.

Farrand (1984) supports the conclusion drawn elsewhere in Africa that the emergent urban Black has generated an informal model of treatment. This model depends on both Western and traditional care. Treatment is described as a two-stage process. The sick person first goes to a Western doctor to get the illness cured, and then goes to an indigenous healer to determine and alleviate the cause of the illness (Farrand, 1984). One reason for the prevalence of such beliefs and practices is that traditional practitioners, who typically diagnose and treat the *ukufa kwabantu* disorders, reinforce these beliefs and practices (Edwards, 1985).

Herselman (1989; cited in Tjale & de Villiers, 2004) proposed that the use of both health services might be to maximise chances of recovery. In a study by Farrand (1984) it emerged that the patients favoured a two-phase treatment plan. They consult a Western doctor while in hospital and then consult a traditional healer at their home. According to Pretorius et. al. (1993), most people who come to psychiatric hospitals for help usually have been to a traditional healer. Edwards (1985, cited in Stricklin, 1990) adds that while Western

treatments are increasingly accepted as the treatment of choice, a combination of the two treatments is common. For Foster and Swartz (1997), there are no communities of pure type [in terms of mental health consumption]. There are hybrids and mixed forms of traditional, modernist and post-modernist tendencies, and particularly local communities. Cheetham and Griffiths (1982) noted that research studies have shown that the combination of different healing modalities and practices has universal outcomes.

3. Treatment packages

Underlying the need to consult traditional healers were attributions of illness conditions to supernatural and magico-social causes. Mainstream health care services are appreciated for dealing with tangible physiological conditions. To deal with the 'real' conditions; and distress around the illness condition, traditional ways would be employed. What would be done when people with a serious health condition seek traditional health care before accepting modern medical services (WHO, 2000)? For example, in a case with *idliso,* STI's and HIV/AIDS; where both mainstream and traditional healers were considered to be useful.

Delays in consulting with mainstream health care would be detrimental. The issue is how could complications that medical doctors have to correct afterwards in hospital and a core cause of contention between health service providers over the years be avoided. A study by Gureje et. al. (1995) in Nigeria found that patients who consult traditional healers first tended to arrive at a tertiary psychiatric service much later than those who consult other carers. To deal with these situations, appropriate training of traditional healers especially on referral skills was recommended. Treatment packages prioritised open communication between health service providers. Green (1995) concluded that, although traditional healers could 'hold' STI's, STI's were best treated by antibiotics no matter what one's convictions are. A

need for an open communication between the western and traditional healers would be imperative. 1) It would ensure that patients have access to antibiotics. 2) It would ensure that they can also access traditional health care they deem appropriate. Health service providers have knowledge of which condition they can or cannot treat and make an appropriate referral.

4. Culture congruent care: culture competence

Much emphasis on this area has been on the interview process. For example, in a study by Kirmayer and Minas (2000), it was found that psychologist limited themselves to natural causes of conditions during the interview process. When compared to the traditional healers whose line of enquiry involved both natural and supernatural causes of illness conditions. The interview process "...various options need to be explored so that without glorifying traditional culture, and without becoming party to emphasizing differences, intervention cohere with the worldview of the client" (Citing Freeman, 1991; Rock and Hamber, 1994). To a practitioner, this calls for the abilities to handle both the biological and the sociocultural aspects of the disorder (Modalvsky, 2004).

For Good, et. al., (2001) the education of clinicians on cultural sensitive and competence is in helping clinicians-in-training to move beyond the mastery of the catalogue of diverse healthcare-related practices. They would examine their own preconceived notions and feelings in clinical encounters with patients from ethnically diverse backgrounds (Good, et. al., 2001). Multiculturalism encourages health care professionals to understand other cultures and traditional practices within the sociocultural context in which they occur (Tjale & de Villiers, 2004). Cultural knowledge is required because caring for people in a multicultural

society requires understanding of similarities and differences of culture and knowledge of inequalities in health care system (Tjale & de Villiers, 2004).

5. Recommendations

5.1 Focus on the illness experience

In multicultural societies there are multiplicities of meanings people attach to the illness experience. A person can be trusted as an interactive partner whose own views and beliefs strongly affect the treatment outcome (Hamber & Rock, 1993). In clinical encounters, the interview process would move beyond the natural causes of conditions. Information about prior consultations with traditional healers would help feature the medical approach in the treatment plan.

Treatment packages complement the illness approach to health and healing. The illness model (Kleinman's explanatory models of illness) proposed that the illness experience would be fundamental in determining the treatment plan. This treatment schedule was envisioned to be patient-centred and hopes to achieve concordance (William & Healy, 2001). It espoused referrals across traditional and mainstream health service providers. A study on STI's in Swaziland by Green and Makhubu (1995); a study on HIV/AIDS in Botswana, recommendation on the treatment on TB in South Africa; recommended greater cooperation between traditional and modern medicine.

In dealing with 'multiple health seeking' MacKian (2003) corroborated findings that access to health care by improving a relationship between mainstream and traditional healing methods is considered necessary. This is a complementary than substitutive that is suggested as the potential role of traditional healers in the treatment of STI's in Swaziland (Green,

1992). Under same conditions Kilonzo and Simmons (1998) advocated that attempts to incorporate traditional and medical care into the health care system must seek to improve the referral skill.

5.2 Collaboration

Collaboration, integration or cooperation between Western doctors and traditional healers is necessary for the provision of an effective mental health care system (Hamber & Rock, 1993). Opposition to such collaboration is echoed by the Doctors for Life. The licensing of traditional healers is from their perspective, detrimental to the economy. This was a position they assumed in a meeting of portfolio committees in reviewing the Traditional Health Practitioners Bill B66 of 2003 (This week in Parliament, 2004). They see danger in healing methods because no rigorous criteria are maintained.

So without the lead of the practitioners themselves, traditional healing would be treated as 'alternative medicine' in medicine and psychiatry (Foster and Swartz, 1997, cited in Yen & Wilbraham, 2003). This is a superficial relationship between the 'cultural' and 'psychiatric' ways where 'alternative' medicine is seen as complementing modern medicine than necessary.

Recommendations in the provision mental health care has pointed towards the need for conceptual reformulation of psychiatry that would be geared towards the provision equitable and appropriate health care; by including cultural aspects in healing (Modalvsky, 2004; Beiser, 2003). Future conceptualisations of mental illness in South Africa should incorporate notions outside the traditional medical approach (Stones, 1996 citing Holdstock, 1979, 1989

& McCutcheon, 1991). This is a call for collaboration with traditional healing theoretically and practically.

In practical situations, validation of traditional healers in a mutual educative atmosphere is a partnership with traditional healers that can help with information dissemination. They can perform roles including as sources of information, and advice on a wide range of social and cultural issues (Ndubani, 1999). The One –stop 'supermarket' approach envisioned by the government (DOH, 2000) points towards the need for existing health facilities to review the allocation of available space and, where possible, relocate MCWH services closer to one another. The optimal integration of MCWH services must be ensured in the design of all future health facilities (traditional healers in the mainstream health care) and birth attendants.

Citing Chi (1999) the WHO outlined six recommendations for effective integration that cover many of the major salient issues:

(1) promotion of communication and mutual understanding among different medical systems that exist in a society;

(2) evaluation of traditional medicine in its totality;

(3) integration at the theoretical level and the practical level;

(4) equitable distribution of resources between traditional and modern Western medicine;

(5) establishment of an integrated training and educational programme for both traditional and modern Western medicine; and

(6) a national drug policy that includes traditional drugs (WHO, 2000).

5.3 Consolidation: Common labelling

Lin and Cheung (1999) are of the opinion that the existence of culture-bound syndromes points to a lack of precise correspondence between indigenous labels and established diagnostic categories. This discrepancy has been exacerbated by what Rhi (2001 and consistent with Bührmann, 1984) refers to as modern psychiatry's neglect of spiritual dimension of the human mind and the teleologic concept of illness and meaningful suffering. Rhi (2001), consistent with Durie and Hermansson (1995, cited in Bodibe, 1998) characterise modern psychiatry as clinging to traditional causality principle and rationalistic orientations without clarifying the concepts of religion, spirituality, culture, and mental health.

The adaptation of or invention of western-based nosologies to understand cultural aspects in traditional mental illness are suggested. The development of diagnostic tools as seen in the work of Cridland and Koonin (2002) is creating a common language and frame of reference for multicultural practitioners, partly assist in accommodating the needs of a multicultural society. Gureje et. al. (2001) attest that cultural views reflect a historical and evolved dynamics in the health seeking behaviours and interestingly the flexibility of labels. These are the ways in which people in different cultures express, experience and cope with feelings of distress.

6 Strengths and limitations of this research study

The use of complementary data is considered triangulation. Triangulation according to Mays and Pope (2000) compares results from either two or more different methods of data collection; two or more data sources; and is more flexible than a mere test of validity.
The exposure to contending views in a group situation helped participants review their position with regard to choices of health service providers; and sometimes get validated,

which can be therapeutic. These participants got the chance the talk about issues that concern them; and recording these issues means giving them a voice. Focus groups can give participants a sense of emancipation and empowerment (Gibbs, 1997).

6.1 Limitations

In self-report studies, it does not usually follow that what people report to do is what they would do or are doing. Compounding to this factor is that openness about traditional healing and its use. This is reported to be a sensitive issue especially with regard to Christian religion. This would affect report on the use of traditional healing methods.

Focus groups are useful in discussing particular topics, but the tendency to self-validate own conceptions in discussing that particular topic is possible. Participants may read and act according to the subtle directions of the facilitator's convictions.

With regard to findings, patterns subservient to medical dualism are assumptions of pluralism. A more historicist critical perspective in Han (2002) perceives medical pluralism as an illusion. It is referred to as the site where capitalism is reproduced and reborn. This is a view that pluralism is within a particular system that has its roots in the division of social classes (Han, 2002). The poor (Petersen, 1998; Lewis-Fernandez and Kleinman, 1995; WHO, 2000; Swartz, 1991) are limited by their socio-cultural circumstance; more so because access is defined by affordability. Pluralism may mean to them that they would use what is available and are left with little or no choice. High costs of health care determine access to health, which much of it is privatised (Pillay & Petersen, 1996).

Despite language and cultural differences, geographically, these health care services are centralised (Pillay & Petersen, 1996; citing Freeman, 1992). Less than half of the respondents were employed and those who were a few could afford medical aid based on the unemployment figures; and annual income findings.

7. Conclusion

From this study, the need for both mainstream and traditional health was evident. Parallel development of traditional and mainstream health care services is desirable. It would depend on a mutual respect and is an acknowledgement as Holdstock (1979; also cited in Pretorius, 1993) noted that before all else, science must be comprehensive and all-inclusive. It must accept within its jurisdiction even that which it cannot understand or explain, that which cannot be measured, predicted, controlled or ordered. If planned and developed appropriately for the national and cultural context, traditional health services can be effective and cost-saving means of providing culturally meaningful health care to the public which has continued to use its services both with and in the absence of modern services (WHO, 2000).

Glossary of terms

1. Health service providers – Stones (1996) and MacKian (2003) extended the reference to 'healers' across board; i.e. both mainstream and informal health care; as opposed to a reference in Good; Good and Becker (2002, Dossa, 2005, Petersen, 1998) exclusively to mainstream [professional] practitioners.

2. Condition – "semantic networks of illness meanings," (Good, 1997, cited in Good, et. al., 2002); "culturally interpreted symptoms," (Low, 1981, cited in Yoder, 2002); "idioms of distress" (Moldavsky, 2003; Beiser, 2003; Ebigbo, 1996; Low, 1985, cited in Yoder, 2002; Nichter, 1981, cited in Good, 2002); narratives of suffering (Kleinman, 1990); expression of distress (Beiser, 2003)

3. Psychiatric conditions – 'mental illness,' are conditions who both African and Western nosologies consider to have cognitive and emotional aetiology (Stricklin, 1990)

4. Culture bound syndromes – "unusual psychiatric disorders" in that they present as psychiatric syndromes that are specific to cultural settings, for example, *ukufa kwabantu* in Zulu people (Freedman, 1976, cited in Edwards et al., 1982), 'piblokto' in Maori tribes in New Zealand (Edwards, et al., 1982); culture-specific idiom of distress that cannot be understood outside the ethnographic context, as cultural beliefs are seen as constitutive of

5. Disease – the malfunctioning or maladptation of biological and psychophysiologic processes in the individual (Tjale & de Villiers, 2004)

6. Medical conditions - 'natural' conditions; *umkhuhlane*, attributes illness to the natural causation. This category is characterised by the modern medical science with its empirical approach, e.g. as in the case of infection, stress, organic deterioration and accident (Murdock, et. al., 1980; cited in Cheetham & Griffiths, 1982)

7. Concordance – based on the idea that patients and practitioners should work together towards an agreement on treatment choice (Stevenson & Scambler, 2005)

8. Patient-centred health care – 'shared decision-making' (Byrne and Long, cited in Armstrong, 2005) the need to address the patient's perspective of his or her illness in the care process (Williams & Healy, 2001)

9. Kleinman's explanatory models of health and illness – a response to patient's suffering based on their personal experience (Kleinman, 1980, 1988; Spiro, 1991; Watermeyer, 1992, cited in Stones, 1998; Williams & Healy, 2001; Good, et. al., 2002; Kgwatalala, 2003)

10. Content analysis - A systematic analysis of the content rather than the structure of a communication, such as a written work, speech, or film, including the study of thematic and symbolic elements to determine the objective or meaning of the communication (The American Heritage Dictionary, 2000).

11. Sample survey – a method of gathering information from a sample of individuals as a basic source of specific scientific knowledge (Scheuren, 2004).

12. *Ukufa kwabantu*/culture-bound conditions – 'disorders of the African people' (Ngubane, 1977, Edwards, et. al., 1983), conditions whose causes are supernatural and magical (Cheetham & Griffiths, 1982)

Reference List

Armstrong, D. (2005). The relationship between medicine and the public: The challenge of concordance. In Health: Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 9(1), 23 – 27.

Bates, S. C. (1999). Does religious healing work? In Neue Zeitschrift fur Missionswissenschaft. 55(4), 259 – 278.

Becker, M. H., Radius, S. M., and Rosenstock, I. M. (1978). Compliance with a medical regimen for asthma: a test of the health belief model. In Public Health Reports. 93, 268 – 277.

Beiser, M. (2003). In review: Why should researchers care about culture? In Canadian Journal of Psychiatry. 48, 154 – 160.

Bodibe, R. (1993). What is the truth? Being more than just a jesting Pilate in South African psychology. In South African Journal of Psychology. 23(2), 53 – 58.

Bodibe, R. C. (1995). Indigenous healing: an indigenous approach to mental health problems. Johannesburg: Vista University.

Bührmann, M. V. (1984). Living in two worlds: Communication between a white healer and her black counterparts. Pretoria: Human & Rousseau.

Burman, E. (1996). The crisis in modern social psychology and how to find it. In South African Journal of Psychology. 26(3), 135 – 142.

Catterall, M. & Maclaran, P. (1997). 'Focus Group Data and Qualitative Analysis Programs: Coding the Moving Picture as Well as the Snapshots'. In Sociological Research Online. 2(1). http://www.socresonline.org.uk/socresonline/2/1/6html

CHED (Centre for Higher Education Development) (2001). Focus group research. In Focus groups. Available Online: http://legacywww.coventry.ac.uk/legacy/ched/research/fogrweb.htm.

Cheetham, R. W. S., & Griffiths, J. A. (1982). Sickness and medicine – an African paradigm. In South African Medical Journal. 62(25), 954 - 956.

Cheetham, R. W. S. & Griffiths, J. A. (1982). The traditional healer/diviner as psychotherapist. In South African Medical Journal. 62, 957 - 958.

Cridland, J. S. & Koonin, S. (2002). Towards a classification of the use of traditional medicine. University of Cape Town: South African Traditional Medicine Research Group.

CSU (2003). Overview: Content Analysis. Writing @ CSU: Writing Guides.

Department of Health (DOH), (2000). Primary Health Care Progress Report. Cluster: Health Monitoring and Evaluation.

Dossa, P. (2005). Racialized bodies, disabling worlds 'they [service providers] always saw me as a client, not as a worker'. In Social Science & Medicine. 60, 2527 - 2536.

Ebigbo, P. O. (1989d). The Mind, the body, and Society: An African perspective. In Peltzer, K. & Ebigbo, P. O. (eds.). Clinical psychology in Africa. Enugu: Working Groups of Psychology in Africa. 89 - 102.

Edwards, E. (1982). Zulu culture bound psychiatric syndromes. In South African Journal of Hospital Medicine. 8(4).

Edwards, S. D. (1985). Some indigenous South African views on Illness and Health. South Africa: University of Zululand.

Edwards, S. D., Borsten, G. F., Nene, L. M., Grobbelaar, P. W., Makhunga, N. V., Kunene, S. T., & Magwaza, A. S. (1985). Indigenous African Healers and Western trained Psychologists: A Comparative Study of Interview Methods. In Research Project Series. B(38). South Africa: University of Zululand.

Edwards, S. D., Grobbelaar, N. V., Makhunga, Sibaya, P. T., Nene, L. M., Kunene, S. T. & Magwaza, A. S. (1982). Traditional Zulu Theories of Illness in Psychiatric Patients. In Journal of Social Psychology. 1983, 121-122.

Eight20 (2004). Township residential property markets: Township Residential Property markets Household Survey (Nov. 2003 – Feb. 2004). In Databases: Consumer Information.

Available Online:

http://www.eighty20.co.za/databases/launcher.cgi?to_launch=/databases/db_summary/fin...

Ellis, C. (2002). The culturally sensitive medical consultation. In South African Medical Journal. 92(4). South Africa: Dando &Van Wyk.

Farrand, D. (1984). Is a combined Western and traditional health service for Black patients desirable? In South African Medical Journal. 66(20), 779 - 780.

Felhaber, T. (1997). South African traditional healers' primary health care handbook. Cape Town: Kagiso Publishers.

Foster, D. & Swartz, S. (1997). Introduction: Policy Considerations. In Foster, D; Freeman, M. & Pillay, Y. (eds.) Mental Health Policy Issues for South Africa. South Africa: Edson-Clyde Press.

Freeman, M. (1992). Negotiating the future of traditional healers in South Africa: differences and difficulties. World Health Organisation. 17-24.

Gibbs, A. (1997). Focus Groups. In Social Research: Update. Available Online: http://www.soc.surrey.ac.uk/sru/SRU19.html.

Good, M. D., Good, B. J., and Becker, A. E. (2002). The culture of medicine and racial, ethnic, and class disparities in healthcare. Available online: https://secure1.sc.netnation.com/~russells/working_papers/199good.pdf

Green, E. C. (1992). Sexually transmitted disease, ethnomedicine and health policy in Africa. In Social Science and Medicine. 35(2), 121 – 130.

Green, E. C. (1994). AIDS and Std's in Africa: Bridging the gap between traditional healing and Modern Medicine. Pietermaritzburg: University of Natal Press.

Green, E. C. & Makhubu, L. (1994). Traditional healers in Swaziland: toward improved co-operation between the traditional and modern health sectors. In Journal of Social Science and Medicine. 18(12), 1071 - 1079.

Gureje, O; Acha, R. A. and Odejide, O. A. (1995). Pathways to psychiatric care in Ibadan, Nigeria. In Tropical Geographical Medicine. 47 (3), 125 - 129.

Gurley, D.; Novins, D. K.; Jones, M. C.; Beals, J.; Shore, J. H.; and Manson, S. M. (2001). Comparative use of biomedical services and traditional healing options by American Indian veterans. In Psychiatric Services. 52(1), 69 - 74.

Hamber, B. and Rock, B. (1993). Mental health and human rights: In search of context, consequence and effective care. In Rethinking Rights. 1, 72 – 91.

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

Jaye, C. (2002). Doing qualitative research in general practice: Methodological utility and engagement. In Family Practice. 19, 557 – 562.

Jilek, W. G. (2001). Cultural factors in psychiatric disorders. In cultural factors and psychiatric disorders. Available online: http://www.mentalhealth.com/mag1/wolfgang.html.

Jilek, W. G. (1998). Transcultural psychiatry – Quo Vadis? In Transcultural psychiatry: Newsletter. XVI(1).

Kahn, M.S. & Kelly, K. J. (2001). Cultural Tensions in Psychiatric Nursing: Managing the Interface Between the Western Mental Health Care and Xhosa Traditional Healing in South Africa. In Kirmayer, L. J.; Lee. S.; Littlewood, R. & Swartz, L. (eds.) Transcultural psychiatry. Hispanic Psychiatry: From Margin to Mainstream. 38(1). Thousand Oaks: SAGE Publications.

Kaptchuk, T. J. and Eisenberg, D. M. (2001). Varieties of healing. 1. Medical pluralism in the United States. In Annals of Internal Medicine. 135(3), 196 – 204. Available online: www.annals.org

Kaptchuk, T. J. and Eisenberg, D. M. (2001). Varieties of healing. 2. A taxonomy on Unconventional Healing Practices. In Annals of Internal Medicine. 135(3), 196 – 204. Available online: www.annals.org

Karlsson, E. L. & Moloantoa, K. E. M. (1984). The traditional healer in primary health care. Yes or No? In South African Journal of Continuing Medical Education. 2, 43-47.

Katz, R. & Wexler, A. (1989). Healing and Transformation: Lessons from Indigenous people (Botswana). In Peltzer, K. & Ebigbo, P. O. (eds.). Clinical Psychology in Africa. Enugu: Working Group of Psychology in Africa.

Kilonzo, G. P. & Simmons, N. (1998). Development of mental health services in Tanzania: A reappraisal for the future. In Social science Medical Journal. 47(4), 419 - 428.

Kirmayer, L. J. & Minas, H. (2000). The future of cultural psychiatry: an international perspective. In Canadian Journal of Psychiatry. 45(5), 438 - 446.

Kgwatalala, G. (2003). Health seeking behaviour among the people of the Africa Gospel Church in Francistown. UNISA: Unpublished Masters thesis

Lin, K. M. & Cheung, F. (1999). Mental health issues for Asian Americans. In Psychiatric Services. 50(6), 774 - 780.

Lewis-Fernandez, R. & Kleinman, A. (1995). Cultural Psychiatry. Theoretical, clinical, and research issues. In Clinical Psychiatry: North America. 18(3), 443 - 448.

Lund, C. & Swartz, L. (1998). Xhosa-speaking schizophrenic patients experience of their condition: psychosis and *amafufunyana*. In the South African Journal of Psychology. 28 (2), 62 - 69.

Lusu, T., Buhlungu, N., & Grant, H. (2001). The attitudes of parents to traditional medicine and the surgeon (a letter to the editor). In South African Medical Journal. 91(4).

MacKian, S. (2003). A review of health seeking behaviour: Problems and prospects. In Health Systems Development Programme. University of Manchester: Health Systems Development.

Mayring, P. (2000). Qualitative Content Analysis. In Forum: Qualitative Social Research. 1(2).

Mays, N. & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. In BMJ. 320, 50 – 52.

Miller, T. & Swartz, L. (1992). Psychology and Epidemiology: An uncomfortable alliance? In South African Journal of Psychology. 22(2), 52 – 58.

Mkhwanazi, M. I. (1986). An investigation of the therapeutic methods of Zulu diviners. Unpublished Masters' thesis. Pretoria: UNISA.

Mkhize, H. (1994). Violent oppression: implications for mental health priorities in South Africa. In Medical Law. 13(1-2), 193-203.

Modalvsky, D. (2004). Transcultural psychiatry for clinical practice. In Psychiatric Times: Special Report. XXI(7).

Morgan, D. L. & Krueger, R. A. (1993). When to Use Focus Groups and Why. In Morgan, D.L. (ed.). Successful Focus Groups. London: Sage.

Ndubani, P. (1999). Traditional healers as a source of information and advice for people with sexually transmitted diseases in rural Zambia. In Tropical Doctor. 29, 36 – 38.

Ngubane, H. (1977). Body and Mind in Zulu Medicine. London: Academic Press.

Painter, D. and Terre Blanche, M. (2004). Critical Psychology in South Africa: Looking back and looking forwards. In Utopia: a draft of a paper submitted to this journal.

Papaikonomou, M. (1991). Views of medical practitioners and psychologists on the inadequacies of the biomedical model and the role of psychologists in its extension. In South African Journal of Psychology. 21(2), 97 – 102.

Peltzer, K. (1995). Psychology and Health in African Cultures: Examples of Enthopsychotherapeutic Practice. Frankfurt: Verlag fur Interkulturelle Kommunikation.

Peltzer, K., (2000). Traditional mechanism for cultivating health in Africa. In M. MacLachlan (ed.). Cultivating Health: Culture Perspectives on health Promotion. John Wiley and Sons, Ltd.

Petersen, I., (1998). Comprehensive integrated primary mental health care in South Africa. The need for a shift in the discourse of care. In South African Journal of Psychology. 28(4), 196 – 203.

Phillips, F. B. (1996). NTU Psychotherapy: Principles and Processes. In Azibo, D. A (ed.). African Psychology in Historical Perspective and Related Commentary. Eritrea: Africa World Press, Inc.

Pillay, Y. G. & Petersen, I. (1996). Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies in South Africa. In South African Journal of Psychology. 26(2), 76 – 80.

Pretorius, E., de Klerk, G. W. & van Rensburg, H. C. J. (1993). The traditional healer in South African health care. Pretoria: Human Science Research Council (HSRC).

Rock, B. & Hamber, B. (1994). Psychology in a future South Africa: The need for a National Psychology Development Programme. Johannesburg: CSVR. Available online: http://www.csvr.org.za/papers/papbrbh.htm

Scanlan, F. (1998). Choices, resources, and medical pluralism in rural Haiti. Available online: http://www.utsc.utoronto.ca/~sosci/ids/summaries/Fiona_Scanlan.html

Seedat, M. and Nell, V. (1992). Authoritarianism and autonomy. 1. Conflicting value systems in the introduction of psychological services in a South African primary health care system. In South African Journal of Psychology. 22(4), 185 – 193.

Statistics Canada (2004). Questionnaire design: Scope and purpose. In Statistics Canada: Quality guidelines. Available Online: http://www.statcan.ca/english/freepub/12-539-XIE/stepsquestionnaire.htm

Stemler, S. (2001). An overview of Content Analysis. In Practical Assessment, Research & Evaluation. 7 (71). Available online: http://www.ericae.net/pare/getvn.asp?v=7&n=17

Sokhela, N. W., Edwards, S. D. & Makhunga, N. V. (1985). Natural and Supernatural Healing by Zulu Indigenous Practitioners. In Edwards, S. D. (ed.). Some indigenous South African views on illness and healing. South Africa: University of Zululand.

Stead, G. B. (2002). The transformation of psychology in the post-apartheid South Africa: An overview. In International Journal of Group Tensions. 31(1), 79 – 102.

Stemler, S. (2001). An overview of content analysis. In Practical Assessment, Research and Evaluation. 7(17). Available Online: http://ericae.net/pare/getvn.asp?v=7&n=17.

Stevenson, F. & Scambler, G. (2005). The relationship between medicine and the public: The challenge of concordance. In health: Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 9(1), 5 – 21.

Stones, C. R. (1996). Attitudes towards Psychology, psychiatry and mental illness in the central Eastern Cape of South Africa. In the South African Journal of Psychology. 26 (4), 221 - 225.

Stricklin, A. B. (1990). Psychopathology: African and Western Attributions. 20 February 1990, Inaugural lecture series.

Swartz, L. (1998). Culture and mental health: A southern African view. Oxford: University Press.

Swartz, L. (1991). The reproduction of racism in South African mental health care. In South African Journal of Psychology. 21(4), 240 – 246.

Rhi, B. Y. (2001). Culture, spirituality and mental health. The forgotten aspect of religion in health. In Clinical psychiatry North America. 24(3), 569 - 579.

de Villiers, L. & Herselman, S. (2004). Metatheoretical and theoretical perspectives on cultural studies. In A. A. Tjale & L. de Villiers (eds.). Cultural issues in health and health care: A resource book for Southern Africa. Cape Town: Juta & Co. Ltd.

WHO Centre for Health Development (2000). International Symposium on traditional medicine held, 6 November 199; Awaji, Japan. Available online: http://www.who.or.jp/media/press/16.html.

Wikipedia (2004). Statistical survey. In Wikipedia. Available Online: http://en.wikipedia.org/wiki/Statistical_survey

Wikipedia (2004). Questionnaire construction. In Wikipedia. Available online: http://www.en.wikipedia.org/wiki/Questionnaire_Construction as retrieved on 4 Nov 2004.

Williams, B. & Healy, D. (2001). Perceptions of illness causation among new referrals to a community mental health team: "explanatory model" or "exploratory map"? In Social Science and Medicine. 53. Available online: www.elsevier.com/locate/socscimed

APPENDIX I

QUESTIONNAIRE

Biographical information

Age		
Gender	M	F

Level of education	Primary Education 1	Junior Secondary 2	Senior Secondary 3	Post-matric 4

Employment/ Profession		**Annual Income**	Below R15 000
			From R15 000 to R30 000
			From R30 000 to R60 000
			From R60 000 to R120 000
			Above R 120 000

1. = Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other

Select the name of the professional/health service provider above indicate which of them you would consult or suggest that a person consult, maybe as an alternative in case the usual profession/person is not there for the specific condition indicated below and why.

(a) ukuthwasa

Why.....

.....

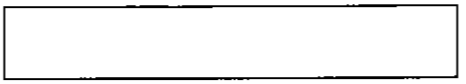
(b) ufufunyane

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

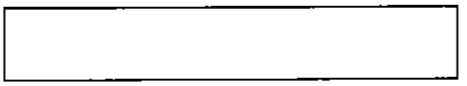
(c) uphethwe ikhanda



Why.....

.....

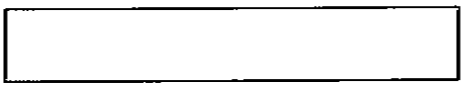
(d) kuzalwa umntwana



Why.....

.....

(e) ukuphambanelwa ikhanda



Why.....

.....

(f) idliso

Why.....

.....

(g) umeqo

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

(h) ukuhayiza

Why.....

.....

(i) umkhuhlane

Why.....

.....

(j) ukukhishwa isisu

Why.....

.....

(k) uphatheke kabi

Why.....

.....

(l) umzimba ubuhlungu

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

(m) ufuna ukuzibulala

Why.....

.....

(n) ibhadi

Why.....

.....

(o) isinyama

Why.....

.....

(p) umsangano

Why.....

.....

(q) idliso

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

(r) ingculaza

Why.....

.....

(s) ukuthuka

Why.....

.....

(t) uvalo

Why.....

.....

(u) inyoni kubantwana

Why.....

.....

(v) umdlavuza

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

(w) ukuhayiza

Why.....

.....

(x) uyaphalaza

Why.....

.....

(y) umkhuhlane

Why.....

.....

(z) isifuba somoya

Why.....

.....

(aa) ibulawo

Why.....

.....

1= Medical doctor, 2 = psychiatrist, 3 = psychologist, 4 = isangoma, 5 = inyanga, 6-= umthandazi, 7 = priest, 8 = social worker, 9 = friends and family members, 10 = other.

(bb) ukudlula

Why.....

.....

(cc) ugcunsula/Thoropo

Why.....

.....

(dd) Ukuvuza (I-drop)

Why.....

.....

(ee) ukuqunjelwa

Why.....

.....

APPENDIX II

TRANSCRIPT: FOCUS GROUP 2

Transcript 2 – Focus group

F -If you remember well, that is, right at the beginning, in this questionnaire, you signed…saying that the information you provided was given voluntarily, and that the researcher can use it according to the needs of the research study he is carrying out. These are the rules we need to do in this country to protect individual and civil rights.

If you look at this questionnaire, I asked you about several conditions and asked you where you would go for a specific condition. What I am asking now is: if you have a headache you indicated that you would go to the medical doctor…why do people go to specific practitioners for specific conditions. I want us to start talking about why does this happen this way and before that I also have a similar document here with me that I was us to sign before we start with the proceedings.

P6: -Sbali; why do we have to sign all the time; you educated people have your own ways.

P5: -Phela, it is law wendoda (my son); as he had explained.

F -Formally now – You are so right ma …Sbali, you filled in this form and signed that you agreed that the information was given voluntarily. I just gave you a paper to sign again that the information to be recorded during this session can be used by the researcher in the same way as the questionnaire you answered. … Now let's start. I want to hear from you…most of you indicated that there are conditions or illnesses that you have to go to *isangoma*, *inyanga* and *umthandazi* for. You also said that these conditions can never be treated by a medical doctor. For instance; *idliso*. What do you mean? How do you explain it? Actually what is this *idliso*?

P9 -Let's say, for us 'Darkies'…It is *izinto zesintu*. It is given to you by people and only a traditional healer can cure it.

F -Explain to me what particularly this *idliso*. If I give you arsenic acid now…I bet you by 12h30 you'll be dead. What is this *idliso* that needs to be 'pulled out' by a traditional healer?

P1 -I want to explain further to what my brother was saying, when he said *idliso* cannot be understood by the medical doctors – he means *izinto zabantu*. What he means is that a person who gives you *idliso* does not want to kill you instantly. It is not like poison that will kill a person over a specific time. It is like magic. It is used in a completely different way than we live. People who give you this can control it. They can make a follow-up on it. It affords not to be seen by a doctor when you have consulted one. This is because people who gave you this know that you go to the doctors.

F -My brother says it is controlled.

P2 -*Idliso* means that a person in Cape Town can give you *idliso*… even when the person is not here. Not that it has to be in food only. It's spirits. As long as this person knows your name – it can get inside you. That's why we say only the witchdoctors can remove it. These

people use 'their animals' – spirits to send *idliso* to you to eat. That's why doctors cannot see it. He even does it such that the doctors cannot see it.

F -My sister, as my brother here was saying that *idliso* works magically. If it is not poison how will I eat it. How do you …

P4 -Sometimes when a person gives you *idliso*, they do not want to kill you. They want you to suffer such that even when you go to medical doctors they won't see it. They do this so that you suffer and lie in bed for a long time. They want to see you in bed. This person is saying, "I want to see Thabile suffering".

F -My sister also says – it is *izinto zabantu*. It is controlled by the bad person.

P9 -It happens that when you have been given *idliso*, you suffer. When I go to the doctors, they will say – it's a stroke. But, it is – *izifo zabantu*.

F -There is a time when you get a stroke from it?

P3 -*Idliso*, for me…I explain it as…when you go to the doctor – *idliso* will run away when X-rays come. You can send it even through air. It's something that is cured using traditional medicine. That is why I agree with my sister when she says it runs away. It can even be sent through air to the person meant for it.

F -Looking at it again it seems to me that you have conditions that you go to the doctor for and the conditions that you have to consult a traditional healer for. My big question here is why? Let's assume we were to live traditionally or move on to getting westernised…

P5 -Sorry, you know…. doctors can hold *idliso* for a short time. When it runs away, they can 'hold it' with their machines. That's why you then have to go to *inyanga*…

P5 -To remove it….

F -For an *inyanga* to remove it, directly.

P5 -They hold it such that you do not get ill. You then have to go to the traditional doctor. I say they must work together. If the western doctor can come together with traditional doctors they can indicate to each other about other conditions that the other cannot fix. They can talk to each, and because this thing [*idliso*] runs away and as a result the doctor cannot see it.

P4 -As momma was saying that the western doctor must work together with the traditional doctor because the medical doctor can hold *idliso*, but he can see that the traditional doctor can heal it. Then the traditional doctor will decide as to whether to give the person something to use to vomit, enema (*imbiza*), and has to use if four times a week. The medical doctor will give him pills and medication to treat it.

F -When you talk about their integration you remind me of the HIV/AIDS. People usually believe that you first have to go to the traditional doctor (*inyanga*) first then to the medical doctor before the treatment can work. Assume this person comes to a hospital and I have to explain to my colleagues – multidisciplinary team (western-trained doctors) – make

me explain to them that this person believes that he needs to go home so that he can do a *'hlaba'* ritual, his HIV/AIDS condition will get better. Explain to me how one would go about explaining this.

P1 -There is something I wanted to explain earlier here. *Idliso* is 'put into' another person by a person. It is not put in by an *inyanga*. So this person wants it work as he has planned it to have it working. He may give you whatever he is giving you and because you are a human being it will work quite as your body is working. It doesn't become a sheep among the herd of goats. It functions according to how your body functions. For example, assume they gave you an *'idliso'* so that you die. You may find that your body cannot 'hold' food. Since the food doesn't stay long in your body, the doctors can help your body hold food and allow it stay longer in the stomach. You may find that when you go and vomit there might be something coming up 'something wrapped in plastic' that you don't even remember eating. The doctors won't know it and they won't find it. The person who gave you *muthi* is very clever. It will change when you go to the doctor. The doctors will think it is TB. It has changed to make itself a TB. The doctors will treat TB. It has changed itself. But this won't affect what you ate; it will remain the same and still trouble you.

F -I'll come back with a follow-up question on that one, but let's first allow this man, he seems like he wants to say something.

P2 -Because HIV is the [*isifo samasoka*] disease that befell those who are promiscuous as it involves sex. Traditionally we can cure some of these sexually transmitted diseases, like *ugcunsula* (VD), drop. Even though western medication can cure drop now, we were able to cure it like pubic lice, and *ugcunsula*. When it comes to the HIV/AIDS issue, as my sister pointed out, they must work together. If *inyanga* can treat all the STD's like *ugcunsula*, they can treat HIV/AIDS too.

F -As a follow-up question ...to come to you my sister again...Assume I went to university and studied for say six years and the money I paid was more than R65 000. You mean a person who went for a year or two years going through *'ukuthwasa'* ritual must sit next to me?

P6 -Undermining one another is a biggest problem here. That I sat at the desk for seven years and that this one is uneducated. That is why this disease cannot be cured. If they worked together maybe they cab find a cure for it. If the doctor has done his job and checked my blood and find out that I am HIV positive. If he does not know what to do with me because they still have find cure, he can send me to *isangoma* or *inyanga* and ask they if they can heal me. The biggest jealousy stems from the fact that it can be impossible for a Black uneducated man would come up with a cure for HIV/AIDS. That won't sound right because he has spent some money – lots of money [to qualify] – maybe if they can work together they can find a cure.

F -You explained it nicely – you remind me of the issue of *ukubuyisa*. Get into my shoes again and help explain to your superiors when you have come over to me telling me that you are going home you want some days off because you want to do a *ukubuyisa* custom over the weekend, of your sister who died sometime ago – you are saying to me that you want some few days off work – Thursday and Friday because on Saturday you have this function. Explain to me – if there are conditions e.g. if the *inyanga* says in order for a person to be cured there must be a ritual to be observed. You then want to go and do that ritual. We

live in a world where maybe as a factory worker it is important for you to be at work. Get into the shoes of a profession in position to explain to the superiors why they have to allow you go home and take the two days off. Say for example you think you have '*ibhadi*' [literary ...bad luck], and you conclude that much of your problems, even the constant fight you have with colleagues here at work is a result of *ibhadi*, and you have. Explain to me how would you explain to a person who is looking at things from the Western perspective that you have *idliso* that the doctors cannot find but that is there without being accused of malingering.

P1 -*Izinyanga* fix up different conditions according to who you are. They will first ask you who you are. For example, we might both go to an *inyanga* for a cure. *Inyanga* may at that time conclude that he can only cure me and not you. *Inyanga* heals you by appealing to you ancestors for help. He will invite your ancestors. He may conclude that since you still have some rituals to observe he cannot heal you because he will just be wasting his time. He uses the powers of the ancestors to heal you. We might even have the same disease and he can decide that he can only work with me because you still have some rituals you have to observe that I have observed. He can go on and work with me.

P5 -I explained to them [employers] that our customs are the same, it just that we do not braai meet. We rather, slaughter a cow and make a big party, like we did when we were having a function for my mother who passed away. We go to the grave and tell her that we are now 'raising' her up and that we are now doing her function.

F -And she can wake up to come and help you.

P5 -To raise her up as an ancestor. They also understand the presence of the ancestors. Although they do not do things like us, they have their own customs to honour their ancestors.

F -She says our customs are the same...

P3 -I agree with my sister. I remember one year ... a proof that white people follow their customs and they '*buyisa*' the dead. There was a friend of mine ... not a friend – in fact a class-mate that I went to school with at Nelspruit, who drowned at the Crocodile River and we had gone there to do the *ukubuyisa* ritual. While we were still there was a white woman who went to the river to throw some flowers. Her son, she told us, had drowned in the river and the only part of his body she found was his hand. Therefore throwing these flowers for them is like remembering their son. And for us when we do the [*ukubuyisa*] ritual we are waking up the dead to come and stay with us. When I looked at it I concluded that there is very little difference between us and them. They do the *braai*, and we slaughter a cow and pour '*inyongo*' (gall bladder) over us.

F -Let me show you the difference you might have not noticed. Let's say when a white person goes to leave flowers at the river, she is not trying to wake the person up so that the dead person can come with her and take care of her, but simply, she is saying I miss you and we had a good time together. When you do that function you are waking up the dead person to come and stay with you...I have heard them mentioning it on gravesides that ... [the dead person] must wake up and come to protect us, don't allow illnesses and bad people to trample on us. Do you think it is still the same?

P3 -It's all the same thing

P9 -It's the same thing, they put it differently in their own language and own culture of being white. We say it more direct. You know how secretive white people are. We put it direct so that everybody understands. You can even notice them fighting a long war with their neighbours. They also go to the graveside they buried ten years ago.

P3 -To confirm that we can look at the scriptures.

F -the Big Book

P3 -One question we can ask is that, since Jesus died, they went to the grave after some time. Why would they go to the grave if there was nothing that concerned them about it?

P9 -Now…

F -This confuses me. I was going to mention the issue of religion. It was nice that you have just mentioned the Bible. There are traditional stuff that talks about *idliso*, which you go to *inyanga* for. So far nobody has mentioned how religion comes to help in traditional healing. You also mentioned the illness, e.g. flu that you have to go to the doctor for to get pills. You are now introducing the third element of religion. There is umthandazi of the Zion church who will give you '*intambo*' [coloured string]. Explain to me how you make sense of this.

P6 -To explain what .. baba

F -I said…my brother mentioned earlier that there are conditions curable by western medicine. If you have flu you get an injection. If you have *idliso*, you do not go to the doctor because he won't know how to treat it, you go to *inyanga*. He is the one who knows how to treat it. He also includes religion. When we talked about all these conditions so far, nobody has mentioned going to *umthandazi* to get *isiwasho* [holy water]. Put *umthandazi* as a healer in the picture for me. How do you make sense out of him. The Bible is in, Christianity is also involved in the healing we are talking about today. How the use of *intambo* comes into it. How do you make sense out of it? … I mean I want to know how you include religion in healing. *Izintambo* that one can get. Explain this to me. How does it treat conditions or heal them?

P9 -Let me say we are different. We people are not the same. OK? There are people who do not use *muthi*, who use *isiwasho* only. Once you use *umuthi* on this person, the person gets more ill. Once you use *isiwasho*, the person gets better.

F -My sister is explains the differences by indicating that there are people who uses *umuthi* and there are people who use *isiwasho*.

P9 It is different …Let's say ….it is different…

P4 -Listen...right…In this issue of religion…let me say you are ill. You have the headache and as momma was saying you are not a *muthi* person; you are a religious person. So, you go to the priest to tell him that you can't sleep and you have tried medical doctors. The priest will not say to you – I am curing you or I am healing you. He is a priest … he will just pray for you. You might even notice that you are feeling

better after Pastor Matheza or Pastor Mavhungo has prayed for you.

F -*Umthandazi*...sorry *umthandazo* – prayer, you might believe that it works or it doesn't that is up to you; ... let's say it works for you ... I assume if you believe it does. There is also someone who gives you isiwasho.

P3&P6 -*Umphrofithi* (prophet)

F -Yes...*umthandazi* or *umphrofithi*. Does that mean the prayer and *isiwasho* [holy water] are the same?

P4 -I think *isiwasho* is water. They pray for it and tell you to go and drink it. It's plain water from the tap. It's not water from the sea or something. It is plain water that *umphrofithi* has prayed for.

F -But when do they come to give me *intambo*. When do you get *intambo*? I have heard that *isiwasho* can be like medication. Where does *intambo* fit?

P5 -*Intambo* as I understand it comes when the prophet has prayed for you. They give it to you after they have 'propheted' to you that you need it. When he prays for you he also prophets you and might give you *intambo* that will 'take care' [strengthen] you – guard you.

P4 -It's like ...*intambo* is used by prophets. Like in the Zion church...say you have feats or epilepsy. When the prophet prays for you he also tells you what is wrong with you. You understand...

F -what the problem is?

P4 -he sees something inside you. You know that different prophets use different colour strings. When they pray for you they then decide on the colour of the *intambo* to give you and where to put it...either on the wrist, or on the waist or on the ankles... then it will be alright.

F -It almost feels like I am going back to my old question again. My sister here has included divination. She says the prophet divines for you before she gives you *intambo*. What I want to find out here is that we also have traditionally a person who divines.

P3&6 -*Isangoma*.

F -Yes. What I want to ask here is who decides to go to *isangoma* and who decides to go to *umthandazi*. What helps you make such a decision?

P1 -There is something I do not understand about people who go to prophets (*abathandazi*). Because to me people who go to *abathandazi* ...You see, we have *inyanga* that heals people who have been bewitched. These people who go to prophets do not believe in this magic of sorcery (bewitchment). They believe that there is a Devil who is out there doing his dirty stuff, but that there isn't sorcery. You won't tell them about *amadliso*. These are the people who prefers *umthandazi*. What I do not understand though in what you are talking about is ... when he gives you

izintambo because there is something he has seen in you ... What I do not understand here is that the person presupposes that what he tells you is told to him by God? They do not believe in *inyanga*, sorcery and bad spirits.

P4 -You know what...

P1 -They do not believe in *izinyanga*, such that they then believe in *isiwasho* and not *umuthi*. So the prophet who tells you what is wrong with you is sent to them by God.

P4&P9 -My brother ...

F -Let's give one another a chance. You'll go first and you are coming next. Let's allow my sister to say something.

P4 -In this issue of sorcery ...Sorcery, for me...I do not believe in it. When an *inyanga* tells you that you have been bewitched ... there is nothing like that ... they just want to steal your money. I want to tell you something. If someone tells you that you have bewitched, they are lying to you. Sorcery for me ... when you talk to your heart... when you tighten your heart and say 'I want to see Thabile suffering'. For me all I see is that I wake up everyday to work, and even though all my efforts are fruitless. I do not gain anything. I then tell myself that I am going to consult *inyanga*, who will throw bones and instead of telling me that Bro...so and so.. has tighten his heart [against me], he will tell me about Bra Velaphi, that it's him. It's him, he placed *muthi* at your gate ...yet Velaphi is someone who is nice to me and with whom I get along very well. When it comes to prayer and all that...Let's say it is the same as when you go *inyanga* for your *idliso* that you strongly believe that it can be cured by *inyanga*. The issue of sorcery ... for me...it is not there.

F -Let me put it this way ...

P2 -What you are saying my sister is that sorcery is not there or you do not believe in it?

P5 -I am not saying it is not there. We have different religions – Bewitchment is there for you and not for the other person. For me, it is your heart.

F - ... before we get out of the topic ...There are few issues I want to enquire about and to put into perspective here. I can see the discussion is getting very heated and I like it that way. But there is a point my brother raised what was interesting to me. He mentioned that the person who goes to *inyanga* or to *umthandazi* for *isiwasho* do so largely because of the belief that his condition will be healed by *inyanga*. But I thought traditionally such a choice is done in ...

P9 -Sorry Bro ... you won't ... when you have a toothache go to someone who fixes up eyes. You'll go to the dentist. If you have a swollen foot, you won't go to *inyanga*. You will go to the doctor.

F -My original question here is when do you decide to go to one of these people and not the other, which is the gist of the matter in our discussion here, and what a reasons for such a decision. What about the family?

P9 -Ok... *Izinyanga* and doctors ... they all heal in the same way. Another person might tell you that he went to a certain doctor and he was helped by him with his ailment. You'll also try and go to that doctor for that ailment. For example, if you have a toothache, you'll go to the dentist.

F -Say ... my lifestyle affords me a choice between these professionals. I have all the doors with professionals of different specialisation accessible to me...

P -It will depend on your illness too.

F -Let me say, as we are staying here, we have the luxury to choose where we want to go, If...say, I am staying at the rural area... chances are they will direct me to a certain...Sbali...over the hill...who has medication for your toothache.

P6 -There are people with good medication for a toothache. Sometimes you do not even need to go to the doctor afterwards.

F -What we are getting at here is that as we are staying here in such a situation and we have the choice of going to any professional of we want for your condition. There are situations in the rural areas where you cannot choose, but rather they will direct and guide you where to go for your toothache.

P6 -I think ...what makes you decide where you want to go is your pocket.

F -That's an interesting one.

P6 -I won't go to the doctor who studied for seven years on credit. The *inyanga* will not charge me as much as he will do.

F -That's an interesting point. Who agrees and who disagrees with it?

P9 -It's true

P3 -Let me say....

P5 -Let me come back to the issue of prayer and *inyanga*. Doctors pray before they do whatever they have to do, so as *inyanga* and even the prophets too.

P9 -...even witchdoctors (sorcerers)

P5 -If you believe it will work for you it will. If you don't you will think you have not been helped with your ailment. If I take a glass of water now and I pray for it when someone who is ill has walked in, and that person believes that it will help him and he believes in me and that I can help him, he'll get better.

F -What you are talking about my sister is very controversial. This is because there are mullet-national pharmaceutical companies, like Pfizer, who sit down extract and mix ingredients and chemicals in order to come up with a pill to give you for flu or whatever. They a pay a lot of money for this. If we can use water as you are suggesting sister, don't you think we can afford to chase these expensive companies and their drugs? They pay so much for this exercise.

P5 -What this means is that I give you water. You also pray to God saying – God, may my ailment get better. I also pray for you. Everybody prays, even doctors pray. Everything done in the name of healing people requires a person to pray first. I also prefer that even when I go to *inyanga*, I ask him to pray first.

F -Even *inyanga*.

P3 -Let me get in here...You see, I am still on the issue of *izintambo*.

F -It is interesting for me as my mother pointed out that people chose where to go for the treatment of their ailment because of economic reasons. What she further explained was that most people cannot afford to pay professionals where a session can go as much high as R220, 00 or even maybe more sometimes. This brings me to an issue of *izintambo* that Sbali wanted to talk about...What does it mean? If I have paid my two rand and got *intambo* what happens? What did you wanted to say on that Sbali.

P3 -I wanted to say – here is *izintambo*. Long time ago, there was *izintambo* made out of hide. If you take incweba ... You know incweba...When you have slaughtered an animal, you put it around your wrist. If you use that hide, it will take care of you. These [*izintambo*] of the prophets are quite different...In fact they are the same in a different way. It's still the same thin, it's just that they do not use hide.

F -As far as I know when you get *izintambo*... Maybe let's start with what we know about when you get *izintambo*. I know that the use of the hide is from the slaughtering of the animal from a ritual, and from which you cut a piece of a hide. *Izintambo* ... what I wanted to know what how do you get to get them. How are they the same or different from the hide? Sbali says they are different in a same way.

P9 -No they are not ...

P3 -They are...

P9 -As far as I am concerned, they are not the same. If you get *izintambo*...that is because you are ill. The traditional hide was put on after a ritual at home. I was and still done today.

P3 -When we go to *incweba*...

P9 -It was the same thing...when you are a baby, they slaughter for you as a way of reporting your presence to the ancestors.

P3 -Even for prophets... You see and adult whose child has *intambo* consults prophets.

P9 -When you for *intambo*, it is because you are ill.

P3 -Even when they are not ill.

P9 -When you go to the [prophet]... that is because you are ill.

P3 -Even when you are not ill.

P9 -You go to the prophet when you are ill.

P3 -Even when you are not ill. You go to *umthandazi* when you get sick.

P9 - He will check you and give you *intambo*.

P3 -Even when you are not sick – You go t *umthandazi* when you know that you are feeling airight.

P9 -Let me ask – what is *incweba* meant for?

P3 -It was meant to protect the child from bad spirits.

P5 -For *umthandazi*, it is for '*ukulahla umntwana*'.

P9 -It is...

P6 -*Incweba...Incweba*...Isn't it something you slaughter for?

P3 -Yes... you slaughter and cut it and give it [the hide] to the child.

P6 -*Intambo* is not slaughtered for, you just get it to strengthen the child.

F -Since you get *incweba* [the hide] at different time than when you get *intambo*. Either *intambo* works as *incweba* was meant for i.e. to chase away bad spirits. When exactly do I get *intambo*. Sbali, If I go to the prophet who gives me *intambo*...What is she saying to me?

P7 -It differs....When he [prophet] gives you *intambo*, he is either saying to that he is giving you something to protect you from the spirits or he is giving you something that...since he has seen that you can function at his level [you can sometimes have the gift to foresee]. So if you get these red and blue coloured strings, it is a sign that works with the divination the prophet came up with.

F -If I remember, My mother (one of the participants) mentioned the issue of the 'bad spirits'. You said there is also a ritual where you have to go and formally wake up the dead person. You are also telling me that there might be this '*umoya omubi*' (bad spirits). Couldn't this late person's spirit be the 'bad spirits' you people are talking about?

P9 -It is our custom as Black people to wake up the dead.

F -Do you know how they explain it> How do they explain *umoya omubi* – what are these bad spirits you are talking about?

P9 -...hey...

F -How do you explain *umoya omubi*?

P1 -*umshologu*

F -How does it happen

P1 -It doesn't happen, it is just there.

P6 -This is how it happens. Let me say I have a new born child. When we have to go to sleep the child does not want to sleep … it cries and screams, climbing over me. The child troubles me and I cannot read what it that is wrong with the child is. Or what exactly the problem is. Maybe when the child eventually gets to sleep, it wakes up looking frightened and scared, and all that. We call this in our culture '*umoya omubi*'.

F -I ask about *umoya omubi* because not only when the child is restless do we think that there is *umoya omubi*. When the person is hysterical, when a person has *ufufunyane*.... and I can even look up some of the conditions here that most people attribute to *umoya omubi*.

P1 -Do you know how it happens? When a dead person's spirit visits home, as we were saying, the dead person who has passed away, he is then given a ritual to go to the ancestors and come back and stay with us. When that is not done, the dead person comes back as a bad spirit. This is because he was not accepted there. The person was not given a walk to meet the ancestors – this is when you did not do a proper ritual to ask the person to come back to you as a good spirit. There are good and bad spirits.

F -What you mean is that…if my close relative passes away. I have no choice, either have to give him a ritual to ask him to come and stay with us, or he will come as a bad spirit.

P6 -Let's not say it is a close relative because it can happen that you are walking out there with a child and you come across 'bad spirits'. They say the child has '*habula*' [was polluted].

P1 -I was explaining to him this *umoya omubi* related to your own place [home]. There are bad spirits that you can come across with out there.

P6 -OK

F -Explain these bad spirits you were talking about …ma. The ones you said you can *habula* out there.

P6 -It cannot be seen, but when the 'working people' [a reference to healers] and older people explain it – they say the child has '*habula*'…you find that the top of the child's skull [*ukhakhayi*] goes down.

P3&9 –Ya … it goes down.

F -Sbali…I can see you are affirming this going down of the skull in a child. How do they explain this '*kuhabula*'.

P3 -*Ukuhabula* is not the same …If you take the child to places where a child is not suppose to be, e.g. a funeral, something to do with death, the child will come into contact with these spirits.

P5 -I say … bad spirits are spirits too. In this world there are spirits – good and bad. If the bad spirit comes into your house – even you, as an adult, cannot sleep.

P9 -True

P5 -That's how we explain them, they are all over the place.

F -Where do I go when I want a cure for this *umoya omubi*? Here I am … where do I go. I am coming to the point we mentioned earlier. Is this when I go to *umthandazi* [prophet] and I get *intambo*.

P -That means the pocket will decide for as to where you can go for help.

F -Let's assume my pocket is beautiful. You are coming back to the point we mentioned earlier.

P5 -You will have to go to *inyanga*, who will come to you household to strengthen it. He may divine for you and will give you *muthi* to '*gcaba*' [incise on the skin]…and all that. The pocket is good.

F -Let's say it is bad now [the pocket]

P -If it is good …I still won't. I won't go to the doctor and tell him that my child cries and do all that…He will say he sees nothing…"What is it?…I see nothing here!' …That's why I'll go to *umthandazi* (prophet)

F -Ma, explain to me how this pocket issue comes in here. Again…
P6 -It's just an opinion

P1 -To me, I do not understand what this pocket thing they are talking about comes into effect. What I know is that if you have an illness,,, and you feel that and you know what the trouble is and you want to get better … the pocket is not important. If you know where to get help…because…I might want to talk about a lot of issues here… and confuse myself.

P6 -Sorry baba…

P1 -I won't say you have to go to *umthandazi*, so that he can give you a R2.00 *siwasho*, and not go where you think you are suppose to go because they are expensive where you want to go. These conditions we are talking about here – if you are suffering from one of them you'll know where to go. Say you have to go to *inyanga* – These conditions does not make you choose they send you to the person. They…

F -Meaning that your choice is not guided by your pocket?

P1 -There are those that if you don't you just have to accept death…

F -He is saying, 'It is not guided by your pocket.'

P1 -It happens that sometimes you have to accept death. Sometimes relatives have to come and do a ritual for you...because you can't do it sleeping in bed ill. That means a lot of spending. You can sometimes work for the whole year[to acquire money to do the ritual]. In that way, these are the conditions that you do not have to choose where you go. I can't prefer to go somewhere else and not where I think I'll get help because it is expensive.

F -There he goes...

P5 -Let's say, baba, you have a problem here at home. You go to *inyanga* and he informs you that there are bad spirits. You also go to *umthandazi* who will tell you the same thing. The *inyanga* wants R250.00 and *umthandazi* only asks for a R50.00. You see...and both divined the same thing.

P1 -You see my sister, when you say you have to go to each of them that means you did not know what your problem is. That is different. When you go inyanga, you will tell him your problem. If you do not know what your problem is – you go to *isangoma* – so that she can divine for you and will also tell you what to do and where to go for further help. Maybe she might suggest that you do a ritual. Most households have their own *amagqira* and *amaxhwele* (*inyanga*) – someone who strengthen the household. In that case you then contact him and he can decide what needs to be done. He won't tell you what problem you have and not point out how it can be sorted out. You won't go to *igqira* who will tell you your problem and not tell you where to go and what to do to alleviate that problem.

P6 -Boetie, let me ask you, doesn't your pocket guide what you can and what you cannot do?

P1 -When it comes to the issues that concern 'death' (*ukufa*) – it doesn't.

P6 -What is death (*ukufa*) now...about?

P9&F -The conditions we are talking about...

F -He means the conditions we are talking about ... to be in ill-health and not well.

P1 -That denotes the conditions we are talking about. To make an example, at one point I have to quit school because I was ill of traditional stuff that as a result of money could be cured at that time.

F -What are you saying on that ma?

P6 -I am still holding that – the pocket guides you.

P9 -In this life – every step you take – it's money. You go around the corner, you have to pour out. These nowadays...You see...at that time when you want to consult people [*abantu* - the traditional healers], your pocket will allow you to go there. Long time ago, we didn't have all the problems, we could use our livestock. You had to pay

chicken, goat, or whatever.

P1 -Because…

P3 -I am with my brother.

P1 -What I believe in is that …

P3 -I do not believe that your pocket guides you.

P1 -I believe that since *inyanga* treats us from what we are suffering from, which is what we've been talking about. I do not believe that you can choose from *inyanga* or something else. These illnesses we are talking about here send you to the right person. If something has happened t you … you have been attacked by bad spirits, and as we have already explained, there is *muthi* on your doorstep you stepped over, and if my foot swells, I won't go to the doctor because I know I won't get help there. I'll go to *inyanga*.

P3 -I believe that one is guided by a belief. Where I think I will get help, I'll go there.

P1 -To go all over the place will cost you money.
P3 -You are guided by your belief.

P1 -My brother …what you can't afford to do is to play. You cannot play and go for *isiwasho* when you know that you have to go to *inyanga*… and simply because you do not have R1000.00 asked for, you then pay a R2.00 for *isiwasho*. You mean that is according to how much you are having and you preferred not to go to where you think you will get help. It's almost like you have chosen to die …because you do not have money?

P3 -You see…I won't go all the way to Chancela. I mean all the way to Chancela. Ride a bus and spend some money, if I can go to my *umthandazi* around the corner. I cannot go all the way to an *inyanga* that helps me. I am of the belief that *inyanga* is for *umuthi*, and I cannot use both *amanzi* [water – *isiwasho*] and *umuthi*. I can only use one that I think will help me.

P9 -You are right … we Darkies believe in different religions. Some believe in God some at *inyanga* and others at *isangoma*.

P3 Ya…

P9 -Some do not believe in sorcery….You'll go where your belief drives you, but you also spend money when you get there.

P3 -It's a belief that drives you. I won't say you won't go where you think you are supposed to go because you do not have money. Even if I do not have money…I'll go *inyanga* if my condition asks me to.

P1 -Another thing here…my brother…is that these traditionally were long ago paid not paid for using money. It happened even when money wasn't around. You had to pay

inyanga a cow. At that time we did not have to choose.

P9 -The cattle you pay today is money. At that time it wasn't cash, but today it's cash.

P1 -That's why I am saying it is because of the way we live today, that we have to choose on the first place.

P9 -You think you are going to get help without spending money...

P3 -I am saying, you are guided by a belief....

P9 -...when you need help

P1 -That is why I was saying my brother that this is because of the way of life we are living now.

P6 -Excuse me...It seems as if you are dwelling on the differences between *inyanga* and *umthandazi*. What they say here is that you are asked to compare all of them, the medical doctor, *inyanga*, *umthandazi* and *isangoma* ... and say which one you would go for...

P1 -We are not asked to compare...

P6 -That's why I was saying you are guided by your pocket.

P3 -...the pocket cannot come in there first.

F -Hold it ...let's give her a chance, she also gave you a chance.

P6 -You will be guided by your pocket...brother, where did you say you were working?

F -1 Military Hospital

P6 -There is an orthopaedic surgeon, where you work?

F -hmmm ....ya...ya

P6 -And as I was saying I won't go to the hospital this brother is working at...it is very good hospital and it is good in orthopaedic surgery. So you won't choose to go there so that they can straighten up your bones. Let me say, the car knocks you down. You won't go to the hospital where this brother works. You'll go to Natalspruit.

P3 -What guides you then? Is it money or your belief?

P9 -Eh...I can't be...

P6 -You are guided by your pocket, not a belief. At the hospital you pay. You don't get the bed free.'

P9 -I can't be knocked down by a car here at Spruit and go all the way to Pretoria, I will

go to Natalspruit.

P3 -In that case I do not have to choose, I won't consult *umthandazi* if I have been knocked down by a car.

P6 -Agree with when I am telling you that your pockets guide you as to where you can go for treatment.

P1 -We cannot agree with you – you are just forcing it down our throats.

P6 -You are guided by your pocket. Agree with me…

P1 -We cannot … you are fighting us.

F -This is quite interesting. But, let's give her a chance to say something.

P6 -Listen. These illnesses people have, things like getting hurt…You can get crippled. If you have your money you will go to the hospital where they will train and exercise you, you might come back walking…Isn't…You are guided by your pocket. You won't go to those expensive hospitals if you do not have money.

F -Let's think about what my mother just said, and see where you agree or disagree with her. If you have been knocked down by a car for example, she does not say your belief does not contribute. She says it is your belief, plus money you have. If you believe that you have to go to a hospital…You'll still go to the hospital though, it's just that it won't be the hospital of your choice if you do not have money.

P1 -Sorry… what I wanted to say is…

P9 -Sorry…

F -We shall start with this brother and you'll come next.

P1 -What she is doing is to make a difference from the same thing, i.e. the doctors and the hospitals. We are talking about *abathandazi*, *inyanga* and the hospital. If you have been knocked down by a car – you'll have to go to the hospital. You do not choose in this case to go either to *abathandazi* or *inyanga*. These for me is a hospital job and you'll have to go to the hospital. You do not have to go to *umthandazi* for a prayer. That isn't about expenses…you just have to go to the hospital.

P3 -Ya

P3 -What I am talking about here is…

P5 -If you want to go to Union Hospital…

P6 -Sorry Boetie…

P5 -You wont; go there if you do not have…

P9 -If you have been knocked down by a car here at Spruit, you won't have to go all the way to Pretoria, You'll have to go to Natalspruit.

P1 -You see now – they are talking about how big or small the hospital is.

P5 -You want to go Union Hospital...Union Hospital, Clinix and Natalspruit. Among these three hospitals, which one are you going to go to? You want to go to Union Hospital...your pocket doesn't afford that. You cannot go to Union Hospital. Which hospital would you choose between the three?

P1 -We understand each other.

F -Let's come back to what my brother was saying. He says that if you have decided to go to the hospital, either expensive or cheap, you have decided that the person to sort your problem out is the doctor. It wasn't you belief in this case to consult *umthandazi* for this ailment, i.e. after you have been knocked down by a car. That's not what you wanted to do.

P5 -It's obvious, you have been knocked down by a car.

P1 -How do you choose if you are saying it is obvious?

P9 -No... this thing is simple and I have mentioned it several times already. When you have been knocked down by a car here, you won't go all the way to other hospitals, you'll go to Natalspruit.

P1 -How does a pocket fit in if it is obvious as my sister was saying?

P9 -If you are...

P6 -Boetie, you choose. You cannot go there if you do not have this card you paid for every month [medical Aid]. You'll go to Natalspruit. Not hat I am saying their care is not 100%. It is... but it is your pocket that affords you good care.

F -After that my brother said that he is not talking about how expensive the hospital is. What he talked about was since you already decided to go to the hospital...you did so because you believe that your ailment will be sorted out there. Then your pocket will come into effect when you decide which hospital you want to go to. For now the decision you have made is that you are going to the hospital.

P6 -What I was doing was to compare these two places.

P5 -For that means that if it is like that for him, that's how he chooses. This is how I choose. If I have R13.00 and I am ill. I won't go to the doctor because he will charge me R80.00, and I only have R13.00. I'll go to Natalspruit because I can also meet a doctor there.

F -That is an interesting one, But even though you choose between the doctor and the hospital, to a large extent you have made up your mind that the medical doctor will help.

P5 -I am confirming what my sister was saying that you won't go to the doctor, I'll go to Natalspruit because I have a R13.00 only and not a R70.00 and I am ill, I need a doctor.

P4 -I used to go to a doctor who charged me R70.00 for consulting him, but because you don't have money today, you'll have to go to Natalspruit.

F -From listen to you I have concluded that there can be reasons why people would go to the doctor...the medical doctor or western ways of healing, and that there are people who also think that there are conditions that a person will have to go to a traditional healer for. The other group thinks that, that is largely influenced by money...i.e. even among the choice of traditional healers. The other group believes that it if predominantly influenced by your belief, i.e. what causes that illness and how a person perceives to be the nature and cause of that ailment. But before we bring session to a close...One more last thing...Is there any point or an issue that a person wanted to talk about and was not given a chance to? ...We are almost closing ... Is there a point you might to clarify or any discussion that you think we might have misunderstood you? That should come from either the question you had after you had filled in the questionnaire or that stems from our discussion today.

P6 -Sorry, there is something you pointed out. You asked as to whether or not our employers understand our culture. That our employers (*abelungu*) understand what it means if you want to go home and observe a certain ritual or you are going to *thwasa* at the *isangoma*...It is difficult...You won't bring as you would when you consult the doctor a medical certificate.

P9 -But Whities [white people – *abelungu*] know exactly everything about our culture. They know our culture. Long time ago, we used to have all these functions and they were observing them. We brew *umqombothi* and slaughter cattle. They also know that things have changed now.

F -What you were asking about sister, to me...it is quite interesting. We have qualified professional health people who have a registration board, formerly known as SAMDC, but now known as the HPCSA. When they have registered and given a practice number, this board keeps the list of the names of those people according to their professional categories for future reference. Now when it comes to a traditional healer you may come at a point where one has a complain that traditional healers gave you 'spoilt herbs'. You will say that this *muthi* you have been given has been polluted and it can no longer work, and you feel cheated. We already have and still need those organisations that can be able to ascertain the credibility of the herbalist who gave you *umuthi*, and to determine which herbs he used and how those herbs work. But before that we still have to argue as to whether we need an integrated health system or not. We also have to create a board where all the traditional healers will be registered and monitored appropriately, such that if you consult them you can get a medical certificate because they have the practice number which is an indication that they are registered with the board. What further complicates issues is education. As you might know some of our traditional healers are illiterate in a Western sense and might sometimes not even know what their practice number is. At this stage the discussions are on the way and the direction is towards collaboration. The need for traditional healers has been identified and at this point we can hope that the traditional

healer will at one point work hand in hand with a western trained professional. It's still a long way to go though.

P6 -What you are saying is that it is still a long way for a traditional healer to work with the doctors next to each other.

F -The recent won fight has been that of the homeopath, a doctor who uses herbs, quite like the traditional healers but in a slightly different way. We wish that at one point you can afford to say with my medical aid that I pay R450.00 for or at minimum R150.00, I have a right to choose who I want to consult for my illness. You should be allowed to get *isiwasho* if you think it is going to help you. I hope with more research work done, as a way Black people can voice out their concerns about their dissatisfaction with what the present health care system is providing, so that we can get as much information as we can to help make decisions about the collaboration possible. It seems to me like it is still a long way but we are getting there. At this stage there might still be an issue about qualifications and all that...but I hope we shall get there.

P6 -That means that for now if you consult an *inyanga* you can still be considered absent from work.

F -You mean you can be considered absent at work if you do not have a medical certificate.

P6 -I mean that means you are absent at work if you have consulted *inyanga*.

F -As I was saying before an *inyanga* cannot issue you a medical certificate we shall need more information to help formulate a structure under which the traditional healers are regulated. It is through such researches that the information can be gathered, so that people in the position of decision-making can make informed decisions. Lastly...any more last thing?

P3.6&9-None

F -I cannot thank you enough for your time. For refreshment we are going to....