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The utilisation of different healing systems by the residents of Daveyton township on the East Rand.

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The utilisation of different healing systems by the residents of Daveyton township on the East Rand.

Mkhululi Dlamini

A research report for the degree Master of Public Health.

University of Witwatersrand

Johannesburg 2000

Declaration

I, Mkhululi Dlamini, declare that this research report is my own work. It is being submitted for the degree of Master of Public Health in the University of the Witwatersrand, Johannesburg.

Thus signed ……

On the …… day of …… 2000.

Abstract

Purpose. A study of the different utilisation patterns of alternative healing systems by the residents of Daveyton township on the East Rand.

Methods. A structured interviewer administered questionnaire was used on adults (18 and older) found in households in Daveyton, which were selected using a stratified random cluster sampling method during the month of July 2000. This method was chosen so as to include all the socio-economic characteristics of the township from informal settlements, old council houses to modern housing. Of the 210 households sampled, 204 were interviewed and 187 had experienced a recent illness or injury in the family. Of these 23.5% were from informal housing, 26.7% modern houses, 40.1 % old council houses, 5.3% new low cost housing and 4.3% from other type of housing. The questionnaire which was administered by interviewers proficient in the all the languages of the respondents asked questions on the personal characteristics of the respondents, socio-economic profile of the family and questions on their help seeking behaviour.

Results. Of the 187 households that had experienced recent illness or injury, the vast majority (70.1%) sought help from the formal health care system – 38.0% consulting general practitioners, 32.1% visiting a clinic or hospital. A surprisingly low figure, 5.3% sought help from traditional healers and 2.7% from spiritual healers. Of the 16.1% of individuals who chose self treatment only 20% used traditional medicines.

Conclusion. There appears to be a strong reliance on western type of health care among the community of Daveyton which amounts to be about 83.5%.

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INTRODUCTION

In an urbanized society a number of therapeutic options are likely to be available for people seeking help for any physical discomfort or emotional distress. This could take the form of self care, seeking help from a friend, relative, neighbour, consult a local priest, folk healer or a doctor. The more modern and complex a society a person lives in, the more likely the society will have different choices of healing systems with many groups or individuals within the society, each offering the patient their own particular way of explaining, diagnosing and treating ill-health. (Helman,1984).

Traditional medicine is an important reality (Pretoriuos, 1991; Patel,1993; Crawford, 1995; Green, Dupree & Zokwe, 1995; Kelly, 1995) among black South Africans where an estimated 80% are said to seek the help from traditional healers when they are ill (World Health Organization, 1983; Freeman & Motsei, 1992; Kale, 1995; South African Health Review, 1999). Even though traditional medicine existed before colonization in South Africa it was banned by the Health Act of 1977 and was never given any official recognition. This has not stemmed the tide of its growth and popularity among the black population. In spite of its increasing recognition in the

late eighties and early nineties as well as its intended integration into the health care system in the ANC health policy documents, traditional medicine still exists outside the legally sanctioned healing professions. (African National Congress, 1994). The biomedical form of health care is elevated above all other forms and both its cultural and social aspects are upheld by law. Other forms of health care are relegated to the level of medical sub-cultures with their own associations, rules of entry, codes of conduct and ways of relating to the patient (Helman, 1984).

Broadly, three sectors of health care can be identified with much overlap between them, the popular sector, the folk sector, and the professional sector.

1. The **popular sector** is the lay therapeutic network where non-professional, non-specialist help is sought. These are all the therapeutic options that people use without consulting either the folk healers or western type health care professionals. The options here range from self-medication to seeking advice or treatment from friends, relatives, neighbours or colleagues at work. This could include healing and mutual care activities in a church, cult or self-help group (which is also for the benefit of other members

of the group); or consultation with another person with a similar experience of a particular disorder, or of treatment of a particular physical state. At this level of care which, is usually the family, most ill-health is recognized and treated mainly by women using materials at hand. The types of medicines used will range from traditional herbs (Varga & Veal, 1997) to western type patent medicines and even sharing another person's prescription medicines. Most health care in this sector takes place between people who are already linked to one another by ties of kinship, friendship, co-residence or membership of work or religious organizations (Helman, 1984).

2. The **folk sector** plays a significant role and is both culturally and spiritually interwoven into the black society (Ngubane, 1977; Tessendorf & Cunningham, 1997; Hess, 1999). This sector is especially large in non-western societies and takes the form of either sacred or secular, or a mixture of the two. They operate outside the legally sanctioned medical system. They form a heterogeneous group with much individual variation in style and outlook; but they are sometimes organized into associations of healers with

rules of entry, codes of conduct and the sharing of information. (Helman, 1984).

Three main types of traditional healers have been identified in the black community:

Inyangas are herbalists and possess extensive knowledge about curative herbs and medicines of animal origin. Ninety percent of them are male.

Isangoma (Izangoma-plural) are usually female and practice as diviners. A person cannot choose to be a diviner but can only be called by ancestors to become one. They determine a person's illness by invoking ancestral spirits. Traditionally sangomas never used herbs or animal parts and would refer an individual who needed such treatment to an inyanga. This role is now blurred with learning how to use herbs being an integral part of the initiation of a sangoma (Ngubane, 1977; Hammond-Tooke, 1989; SABC Special Assignment, 1999).

Umprofethi (amaprofethi – plural) are faith healers who are professed Christians and belong to independent African churches. Faith healers usually operate independently, though there are major

traditional African churches that practice healing with certain individuals in those churches designated as healers. The healing methods in these churches vary widely from those using just prayer to those who use water, ash, coffee, tea, vinegar and pepper among many substances (Mariba, 1999; Mhlanga, 1999).

Traditional midwives are identified in other studies but these are not expected to play a major role in an urban setting (Trostie, 1997).

Other forms of alternative healing that exists in a more Western society like homeopathy and acupuncture though rare cannot be excluded in an urban black township.

3. The **professional sector** is the orthodox medical system which, in an urban township is characterised by a mixture of private and publicly provided care. The general practitioners (GP), dentists and primary public health facilities like clinics usually provide the first line of care. Secondary and tertiary care is provided at hospital level (private and public) which are generally accessible even though they may not be within the township itself. There is also an emergence

traditional African churches that practice healing with certain individuals in those churches designated as healers. The healing methods in these churches vary widely from those using just prayer to those who use water, ash, coffee, tea, vinegar and pepper among many substances (Mariba, 1999; Mhlanga, 1999).

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of new private managed care facilities which operate like clinics providing perceived quality care and are generally priced less than the GP fees. The nurse practitioners as well as the pharmacists have also entered the private primary level of care. (Helman, 1984; Micozzi, 1996).

Even though South Africa has an estimated 200 000 traditional healers as opposed to 23 000 allopathic doctors and for many South Africans the first point of contact being through a traditional healer (Hadebe, 1999; South African Health Review, 1999), studies have varied widely on the utilisation of these different health services. Tom (1992) , in his research report for the degree of Master of Family Medicine found that 73.5% of the patients they interviewed in the outpatients department of Umtata Hospital had been to a traditional healer at some stage of their lives. A much recent study by the Department of Sociology, University of Witwatersrand (Morris, 1999) on a survey of Soweto in the late 1990s found that only 1.5% of the population had consulted a traditional healer. The study cited the reluctance of people to volunteer information about their visits to traditional healers in an urban setting. There is also a problem of the effect of deference when interviewers are coming from the realm of orthodox western medicine the

responses are likely to be those that respondents perceive are perceived by interviewers (Fowler, 1995). It is without a doubt that more studies on the people's help seeking behaviour are needed to aid in informing public health policy.

Modern medicine has not been able to adequately address all health needs. It is not surprising that traditional healers are gaining an increasingly dominant role in the struggle against HIV/AIDS (Strang & Swift, 1993; Hadebe, 1999; Ndubani & Hjer, 1999) with many countries like Namibia fast tracking legislation to utilize an untapped resource, which could be used in community-based health care programmes (May, 1998).

A new set-up that utilizes the services of a variety of healers in primary health care and integrates them into the health care system where they will earn respect from both the community and western type health care workers has to be found.

From the public health perspective it would be of assistance to policy planning if the measurable factors that influence a person's choice of a healing system were known. For this reason the association between socio-demographic variables like sex, age, occupation, educational level, household

income, type of dwelling, employment status and status in the family, will be examined. Qualitative information on the perceptions of the nature of the illness, perceptions of the seriousness, previous experience with the health care systems will also be explored.

In addition, a study that looks at why individuals choose a particular type of healing system and what might be the variables associated with those choices will help in informing decisions on health policy development.

Purpose.

To establish utilisation patterns of different healing systems and the factors that are linked to their use among the people of Daveyton.

Objectives.

(a) To determine a demographic profile of respondents which will include the variables: age, sex, marital status, income, occupation, educational level, household income, type

of dwelling, employment status and status in the family.

(b) To explore the utilisation of healing systems, in particular: the nature of illness experienced, the type of healing system chosen; and the reason/s for that choice.

(c) To determine/examine/explore the relationship between (a) and (b).

MATERIALS AND METHODS

Population.

The population under study is in Daveyton, Benoni, which is situated on the East Rand about 30km east of Johannesburg, an old black township established in 1955 originally comprising of the similar rows of the so called 'matchbox' houses. The late seventies saw a growing middle class and later a burgeoning informal settlement. Services are provided by the City Council of Greater Benoni and these reach the informal settlement which enjoy electricity, refuse removal,

water borne sewerage and tap water at least within the yard of every individual households (Greater Benoni City Council,1999). The population is served by about six public clinics, two of which are health centres. Benoni has 4 private hospitals, 1 South African National Tuberculosis Association hospital and is serviced mainly by two public hospitals, which lie outside Benoni in Springs and Boksburg but both have up to 70% of their intake of patients coming from Daveyton. A well run emergency service under Greater Benoni City Council services the area and will also transport patients to both the public and private hospitals. There are 30 general practitioners and an estimated 500 traditional healers who belong to three identifiable organisations, namely, Uncedo, Traditional Healers Organisation and Isambane. One organisation alone, Uncedo, has 280 members in its books. The benefits of belonging to these organisations include recognition by peers in the form of a certificate issued, legal assistance to members for actions resulting from practising his/her profession, sharing and extension of knowledge and assistance in the procurement of herbs and other medicinal substances.

From the east to the west of the township there are distinct socio-economic differences. For purposes of this study it was easy to divide the population into four groups:

- those who live in informal settlements;
- those who live in old four roomed council houses;
- and those who live in large modern houses where often they have to take out bonds (middle class areas);
- residents of the new low cost housing;

The size of the population for Greater Benoni is 616 352 with the following breakdown: whites 86 927, Asians 20 098, coloureds 2 079 and blacks 507 248. The black township of Daveyton has a population of about 430 000 according to the 1996 census with 50 000 living in middle class areas, 300 000 old council houses and 80 000 in informal settlements (Greater Benoni City Council, 1999). There are however many instances where one would come across a huge modern house among shacks and there is a large number of improved homes in the old council areas. For the purposes of sampling the area will be classified according to the predominant type of dwelling. The type of dwelling will be recorded as it appears irrespective of the area in which it is built.

Study sample.

Households living in all the areas of Daveyton were selected for the study using a multistage cluster sampling method. This method was chosen because of the distinct socio-economic differences which are determined largely by geographic area within the township. A simple random sample was not feasible, nor was the multistage sampling necessarily better. The township was divided into four areas according to the predominant type of housing and each area type was divided into several units of between 6 to 8 with a population of about 20 000 in each unit.

From each unit a cluster sample was then selected of about 10 households. As each stand, including those in the informal settlement is numbered, maps obtained from town planning were used and sampling was done by generating random numbers from a scientific calculator until about 10 households were sampled from each category. This resulted in sample size of about 210 households. It was decided beforehand that if more than one household lived on one stand all will be interviewed. Because of multistage sampling method, confidence intervals are 10% either way. (Abdool Karim, Katzellenborgen & Joubert, 1997).

Measurement.

A structured interviewer administered questionnaire (Appendix 2) was used to collect information by asking relevant questions to do with the study. Information was collected from adult persons mostly women found in the household about their recent experience of ill-health preferably in the past year (the period was chosen so as to minimize recall bias). Questions were asked about what they thought their illness was, whether they went for treatment or not for it, where they went, their experience with help there and what type of help they would seek in future. Other demographic characteristics like type of dwelling, age, sex, educational level, status in the family, income, marital status, family size, occupation and employment status were asked. Interviewers were trained to ask sensitive questions like income at the end of the interview when the rapport has been built.

The questionnaire was in English but interviewers were English speaking as well as proficient in all the languages of the respondents. The questionnaire provided a full script of how the questions should be asked. The translation into Zulu and Sotho was standardised so that it elicits consistent

responses. The questionnaire was tested on a few selected individuals to see if it elicits the same response. The interviewers were recruited by Sister Josephine Nonkonyane who works for the Cancer Association of South Africa (CANSA). They are volunteers of CANSA who are involved in provision of home based care. Some of them had experience with social enquiry gained through working part-time for market research companies. They were a total of six and were split into two groups each guided by a qualified nursing sister who also did interviews. They were trained by first giving them a background of what the whole research project is all about and then training was given in interviewing and interpersonal skills as well as how to record the responses. Interviewers were also advised not to project a medical perspective specifically to avoid the possible deference effect on the respondents (Fowler, 1995). The interviewers were selected on their proficiency in all three languages.

Logistics.

Using the above sampling method resulted in the sample size of 210 households. To expedite data collection 8 fieldworkers were used, each responsible for about 25 households.

Each field worker was allocated time of at least two weeks but most took about 3 weeks to complete the questionnaires. This time allowed at least two visits per person per day and gave enough time for subsequent visits if no person was found at home. If a household which was skipped because there was no one home . The time of the interview was mostly in the evenings between 5.00 and 7.00pm on weekdays or on mornings 8.00 to 10.30am during weekends. If an adult person was found an interview took place. An adult for the purpose of this study is an individual who by South African law does not require any parental consent for any decision about all his/her health care needs, i.e. 18 years. Appointments were made by phone when the latter was available and time booked. Repeat visits were made if no one was found at earlier visits. It was my responsibility to co-ordinate the research project. Each fieldworker made use of a work sheet (Appendix 1) which recorded all the activities of the day stating exactly what his or her starting point was, stand numbers of households visited and what was the outcome of visit. The work sheet had a column for the second visit. One work sheet was used for each fieldworker. To ensure that fieldworkers actually did their work an agreement was entered with them that random checks on the households visited will be made.

Fieldworkers without their own cars used public transport for travel. For informal settlements men who were used to working in the particular area were chosen to conduct the household interviews there. Most interviewers did not express any apprehension about visiting any area. Some money was given in advance to help with transport, meals and be able to make calls in case help was needed. All interviewers felt there was no need for any police protection for going into any of the areas selected.

Pilot study.

The questionnaire was tested on a few individuals not randomly selected but a convenient sample of mostly friends and people attending the surgery. This was done mainly for the purpose of refining the questionnaire and ensuring that the same response is elicited each time a question is asked by a different interviewer and in a different language. A small random sample of about 10 households was selected to test the project under similar circumstances to those that will be encountered during the actual research. Those who participated in the pilot study were excluded when sampling for the main study.

Bias and limitations.

A potential area of bias is in the sample selection method. Care was taken that areas of all the socio-economic levels were included in the sampling. This has been dealt with in the selection of a sample using a stratified method and then randomly selecting clusters.

Inter-observer variation was overcome by using skilled people in the form of registered nursing sisters as well as community volunteers with prior experience in social enquiry. They were all provided with additional training on conduction of interviews and recording of information to ensure standardisation and uniformity of the interviewing skills.

Recall bias of experiences was eliminated by limiting the questions to the most recent experience of ill health or injury preferably but not necessarily limited to not more than a year.

People omitted from the study because they were never found or those who refuse to participate could introduce bias in the result if these could be sharing a particular characteristic which determines their behaviour. Every effort was made to

ensure that the response rate is high. Co-operation of the participants with their informed consent was enlisted. A small number of those who were not interviewed is included in the results.

Data processing.

The Epi Info programme was used for data capture and analysis.

Ethical considerations.

Permission from the Wits University Ethics Committee was granted to conduct this research and the Medical Officer of Health of the Greater Benoni City Council was informed and indicated that there was no need to seek permission from the council to conduct the research. I spoke to a few councillors who expressed a keen interest in the research.

Questionnaires were accompanied by a leaflet explaining exactly the purpose of the study, its benefits and any potential harm. To ensure uniformity of this information it was written down and the interviewers were asked to read out the information to the participants. It was explained to them that it is within their right to consent to participate in the study

and refusal was not going to prejudice them in any way. It was also explained to them that even though the results of the survey would not benefit them as individuals it would benefit the community as a whole because the information obtained from the study would assist in the formulation of public health policy. The confidentiality of the information they provided was guaranteed as no respondent's characteristics that identified them was recorded (see appendix 2).

All assistance received towards the project is acknowledged and there is no conflict of interest.

While a report of the research has been submitted to the University of Witwatersrand as fulfilment of the requirement for the degree Master of Public Health, the results of the study will also be published in scientific journals to help contribute to the body of scientific knowledge. The local authority as well as any other party with interest in the study will be given a report of the findings.

A simplified easy to read report will be provided to the communities that participated. This will be through their representative civic leaders as well as interested individuals.

RESULTS

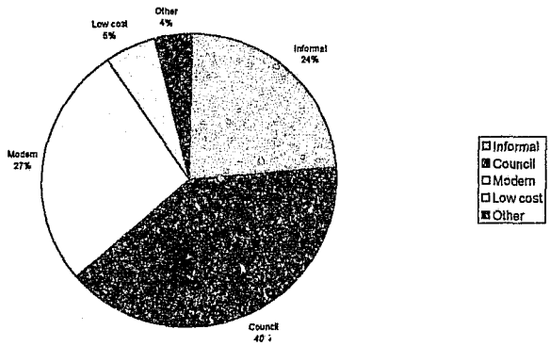
Response rate.

The response rate of the study was high being 97.1% of the sampled household. Only 6 of the 210 households sampled were not interviewed. Two refused to participate and four were never found at home after more than two visits at different times. Neither those who refused nor those who not found home shared any particular characteristic. Of the 204 households visited and interviewed 187 had experienced a recent illness and 17 (9%) had not experienced any recent illness and the interview did not go further.

Socio-economic characteristics of the population.

A breakdown of the type dwelling of the households interviewed is given in figure 1.

Figure 1. Type of dwellings.



The large number of old council houses (40%) is in keeping with the predominant type dwelling found in the township of Daveyton. However, the high percentage of 27 for the modern houses represents also a significant proportion of these type of houses that you would find among old council houses. A lot of families found in this area appeared to be pretty well off with quite large and beautiful houses. The older and more established informal settlements, particularly those originally established as site and service schemes, when financial institutions still offered loans to these areas, were not far behind with a few middle class families. The number of informal structures (24%) are also difficult to measure because even the old council area there are a number of backyard shacks built more or less to the same standards as

the houses in informal settlements. New low cost housing project represent a more homogenous uniformity at 5%.

The vast majority of respondents were female at 67.4% and the breakdown of the ages is given in table 1. It is this group, usually mothers and grandmothers, that are main providers of care which, could range from self care with materials at hand or responsibility for taking decisions on who to consult (Chrisman, 1977).

Table 1. Age distribution of respondents.

Respondent's age	Frequency	Percentage
18 to 20 years	15	8.0
21 to 29 years	42	22.5
30 to 39 years	48	25.7
40 to 49 years	42	22.5
50 to 59 years	21	11.2
60 to 69 years	9	4.8
More than 70 years	10	5.3

Most of the respondents (70.7%) were between the ages of 30 to 49 years, fewer were older than 60 at 10.1% and only 8.0% were 20 years or younger.

The respondent's educational status is outlined in table 2. One of the respondent's age was not recorded, hence the total of 186.

The highest grade passed was recorded and if no education at all the grade was recorded as zero.

Table 2. Educational status.

Grade passed	Frequency	Percent	Cumulative
0	16	8.6%	8.6%
1	1	0.5%	9.1%
2	1	0.5%	9.7%
4	1	0.5%	10.2%
5	7	3.8%	14.05
6	8	4.3%	18.3%
7	12	6.5%	24.7%
8	20	10.8%	35.5%
9	10	5.4%	40.9%
10	23	12.4%	53.2%
11	19	10.2%	63.4%
12	68	36.6%	100.0%
Total	186	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
186	1679	9.027	12.956	3.599	0.264
Minimum	25%ile	Median	75%ile	Maximum	Mode
0.000	8.000	10.000	12.000	12.000	12.000

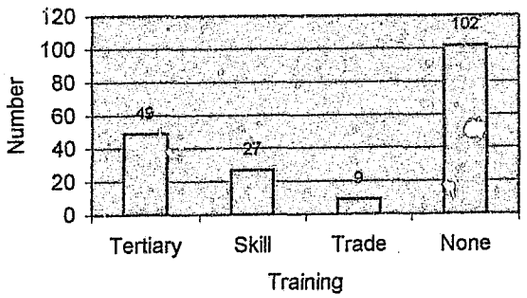
Student's "t", testing whether mean differs from zero.

T statistic = 34.203, df = 185 p-value = 0.00000

Only 8.6% of the respondents have had no education at all. More than 89% have had at least 4 years of primary education. Up to 36.6% of adults have completed high school. The literacy level

are well above the national average of between 50 to 60%, but it is possible that people could have overstated their educational levels as there was no mechanism of verification. Respondents were also asked whether they had received any training and these were grouped according to those that received tertiary education, those who acquired a particular skill not necessarily through tertiary education, those trained for a particular trade and those who had no training at all as illustrated in figure 2.

Figure 2. Training received after or outside schooling.



More than half of the respondents (54.5%) had no form of training at all, while 4.8% had some form trade mainly bricklaying, sewing and child care training. Those with skill (14.4%) included mechanics, electricians, sales people, welders and computer skills and did not necessarily complete their school education. Those that have tertiary education at 26.2% represented mainly teachers and health professionals. Certain categories of civil servants like police, correctional

services personnel were also classified as having received tertiary education. Table 3 represent the spread of the occupations found.

Table 3. Distribution of occupations.

Occupation	Frequency	Percentage
Professional	35	18.7%
Businessman	6	3.2%
Artisan	3	1.6%
Labourer	17	9.1%
Domestic worker	15	8.0%
Informal business	12	6.4%
Pensioner	14	7.5%
Student	21	11.2%
Unemployed	63	33.7%
Other	1	0.5%

The inclusions in the category of professional were more generous in that even sales representative, brokers and white collar workers irrespective of their educational level, such as clerks, were classified as professional. Businessmen were those involved in formal businesses like owning shops, taxis, etc. while informal businesses involved street vending and some form of selling or providing a service like looking after children from home. There was a high unemployment rate among respondents (33.7%) which is higher than the national average of around 23% (StatSA, 2000). This figure is sometimes inflated by respondents who may be engaged in some kind of income generating activity but do not regard that

as employment, like looking after a working relative's child who would give him/her some money for doing that.

There was a relationship between the occupation of the respondent and the type of dwelling as indicated in table 4.

Table 4. Occupation of respondent and type of dwelling.

	Type of dwelling					
Occupation	Informal	Modern	Low cost	Council	Other	
Professional	2	24	2	6	1	35
Businessman	5	3	0	7	2	17
Artisan	3	0	0	0	0	3
Labourer	1	7	2	6	1	17
Domestic	2	2	3	7	1	15
Informal	1	0	0	0	0	1
Pensioner	1	1	0	11	1	14
Student	4	7	1	9	0	21
Unemployed	25	6	2	29	1	63
Other	0	0	0	0	1	1
Total	44	50	10	75	8	187

Chi square = 112.24
Degrees of freedom = 36
P value = 0.000000

Professional people live predominantly in modern houses – 686 per 1000 compared to say domestic workers at 133 per thousand which gives a 5.15 times higher chance. Pensioners are predominantly in old council houses – 785 per 1000 as compared to informal settlements and modern houses which are both at 71 per 1000. The unemployed are mostly in the

informal settlements and old council houses and are both at 396 per 1000 – in modern houses the rate is 95 per 1000.

The families' main source of income and the joint household income as given by the respondents are listed in table 5.

Table 5. Family income.

	Joint Monthly Household Income (R)					
Source of Income	**<500**	**500-1000**	**1001-2000**	**2001-3500**	**>3500**	**Total**
Formal employment	4.3%	13.4%	15.5%	10.2%	8.6%	51.9%
Informal employment	3.2%	2.7%	1.1%	0.0%	0.0%	7.0%
Self employment	6.9%	3.2%	2.7%	0.5%	1.1%	14.4%
Other	13.4%	10.7%	2.1%	0.0%	0.5%	26.7%
Total	27.8%	30.0%	21.4%	10.7%	10.2%	100.0%

Up to 51.9% (97) are in formal employment with only 16.5% (16 out of 97) of this group having a joint household income of more than R3500. None of the people whose income came mainly from informal activities had a joint household income exceeding R2000. People in self employment did not appear to do that well with 48.1% (13 out of 27) of this category falling below R500. Other sources of income were comprised mainly of pensioners – old age and disability grants. Many families were relying on one member – usually an aged parent receiving a pension for their survival. Other sources were

also people relying on maintenance grants and care dependent grants from the state. Financial assistance from relatives and maintenance payments from fathers of divorced or unmarried mothers was also part of this category.

There was a relationship between joint household monthly income and type of dwelling as it is outlined in table 6.

Table 6. Joint household income and dwelling type.

Joint household income(percentages in brackets)

Dwelling	<500	501-1000	1001-2000	2001-3500	>3500	Total
Informal	30(16.0)	8(4.3)	6(3.2)	0(0.0)	0(0.0)	44(23.5)
Modern	1(0.5)	7(3.7)	13(7.0)	13(7.0)	16(8.6)	50(26.7)
Low cost	4(2.1)	1(0.5)	4(2.1)	1(0.5)	0(0.0)	10(5.3)
Council	16(8.6)	35(18.7)	15(8.0)	6(3.2)	3(1.6)	75(40.1)
Other	1(0.5)	5(2.7)	2(1.1)	0(0.0)	0(0.0)	8(4.3)
Total	52(27.7)	56(30.0)	40(21.4)	20(10.7)	19(10.2)	187(100)

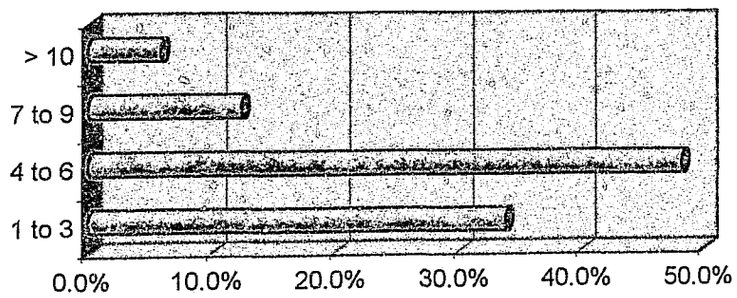
Chi square = 110.62 Degrees of freedom = 16
P value = 0.00000000

A large majority of higher income earners are more likely to live in a modern house than those in the lower income groups. Five hundred and eighty people per thousand earning above R2000 live in a modern house as compared to 120 per 1000 that live in an old council house and 100 per 1000 in low cost housing. Conversely, people earning below R500 are more likely to live in an informal settlement – 682 per 1000 as compared to 213 per thousand in an council

house. Those earning between R501 and R2000 are more likely to live in an old council house – 667 per thousand in old council houses and 213 per thousand in a modern house.

The size of families were largely in the category of 4 to 6 (48.1%) as illustrated in figure 3. Only 18.2% of the families had more than 7 family members and even fewer (5.9%) had more than ten family members per household.

Figure 3. Size of families.



The vast majority of households had only one family per stand as outlined in the following table. The mushrooming informal settlements, low cost housing and site and service schemes appear to have reduced the need for backyard squatting. One family per stand were a most common feature (86.1%) of all types of households interviewed. More than one families per stand were mostly found in the old council houses and less frequently in informal settlements.

Table 7. Families per stand.

No. of Families	Frequency	Percentage	Cumulative	
1	161	86.1%	86.1%	Mean 1.22
2	16	8.6%	94.7%	Median 1.00
3	5	2.7%	97.3%	Mode 1.00
4	5	2.7%	100.0%	Std dev 0.62
Total	187	100.0%		

Help seeking behaviour.

This is the main focus of the study and we start by looking at the profile of illnesses found which were classified into main groups of illnesses and laid out into major categories as illustrated in table 8.

Table 8. Profile of illnesses.

Illness	Frequency	Percent
Gastrointestinal	16	8.6
Hypertension	17	9.1
Injury	14	7.5
Mental illness	14	7.5
Musculoskeletal	13	7.0
Respiratory	64	34.2
Integumentary	17	9.1
Tuberculosis	6	3.2
Headache	6	3.1
Witchcraft	4	2.1
Unknown	3	1.6
Other	13	7.1

The most predominant type of illness at 34.2% of all illnesses reported were of respiratory nature which remains an important cause of morbidity and mortality especially among children in South Africa (Klein, Von Schirnding & Yach, 1991). This is a typical pattern at primary health care level (Morris, 1999) and the commonest complaints in this group of illnesses were mainly colds and flu's. Another explanation could be that these are quite easily identified and are readily associated with the biomedical model of care. Tuberculosis (3.2%) was classified separately. Hypertension, gastrointestinal and integumentary (skin) diseases were the next frequent group of illnesses followed by injuries, musculoskeletal and mental illnesses. On the category of "Other" illnesses that could not be classified because of uncertainty of the respondents about what to call that particular ailment.

The ages of the members of the family who had experienced illness ranged from a few months to over 70 years. The mean age was 31.305 and the median was 30.000. the standard deviation was 20.060 and the standard error 1.467.

There were slightly more female members (51.9%) of households than males (48.1%) that experienced illness as illustrated in figure 4. This trend is supported by literature

internationally (Ashley, Fox, Gertley, et al., 1994; Dammon, Formanek, Ladwig, et al., 2000). The exception in the South African Sentinel Practitioner Research Network (SASPREN) study on general/family practitioner consultation patterns of the Western Cape population, females outnumbered males in all race groups except blacks where they comprised 48% of the population.

Figure 4. Sex of family member experiencing illness.

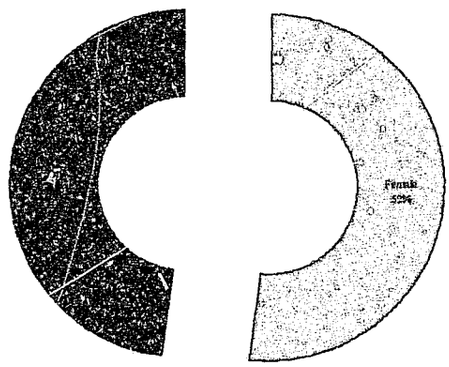


Table 9 illustrates the family status of the ill member of the family. The children were most likely to be ill than any other member of the family at 37.4% followed by mothers at 20.3%. The fathers in the family were the third most likely (12.8%) to be ill members of the family followed by the spouse and siblings at 10.2%. The category of 'other' (9.1%) comprised of other relatives like aunts, uncles, cousins and foster children among others. Those with no source of income of their own

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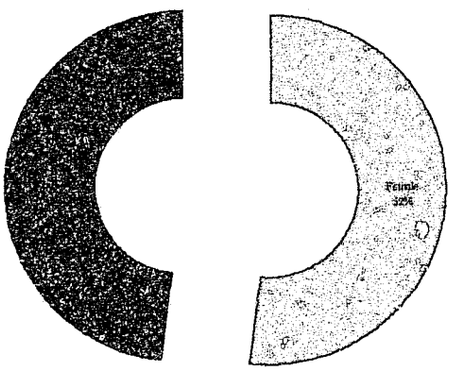

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like children, students and the unemployed together constituted 61.0% of the members of the family who experienced illness. The unemployment rate of 25.7% among those who were ill was closer to the official definition national average of 23.3% (Statistics South Africa, 2000) than the rate of 33.7% found among respondents, which is closer to the national expanded definition rate of 36.2% (Statistics South Africa, 2000). This high figure is probably due to bias in the sense that the unemployed are most likely to be found at home. Pensioners at 9.6% are a different group from the unemployed as many of them earn an income and in a community were income levels are low do very well. The also benefit from exemption on fees at public facilities and are often given discounted rate in the private sector.

Table 9. Family status of ill person.

Family Status	Frequency	Percentage
Child	70	37.4%
Father	24	12.8%
Mother	38	20.3%
Spouse	19	10.2%
Sibling	19	10.2%
Other	17	9.1%
Total	187	100.0%

If we also look at the occupational status of the ill persons as outlined in table 10, it is striking that those that could not pay for their own health care, preschool children (11.2%), students/pupils (24.1%) and the unemployed (25.7%) formed

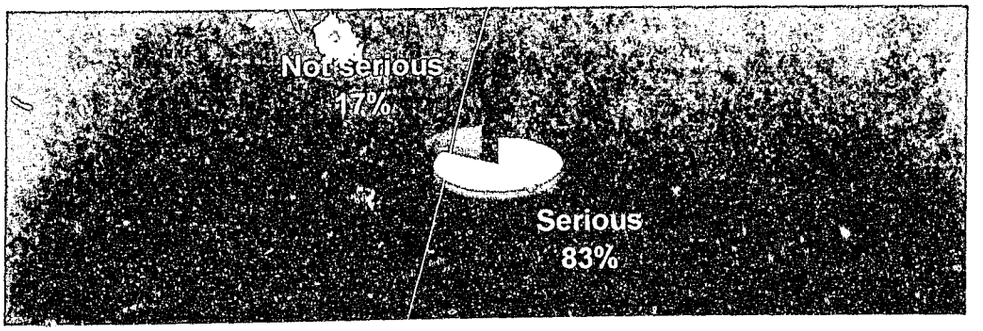
the vast majority (61.0%) of those that needed care which imposes a heavy dependency burden on the community.

Table 10. Occupational status of ill person.

Occupation	Frequency	Percentage
Domestic	9	4.8%
Labourer	17	9.1%
Preschool child	21	11.2%
Pensioner	18	9.6%
Professional	18	9.6%
Self employment	11	5.9%
Student/pupil	45	24.1%
Unemployed	48	25.7%
Total	187	100.0%

Most of the respondents (82.9%) thought their illness was serious and only a few (17.1%) at least initially thought their illness was not serious as shown in figure 5.

Figure 5. Opinion of respondents to seriousness of illness.



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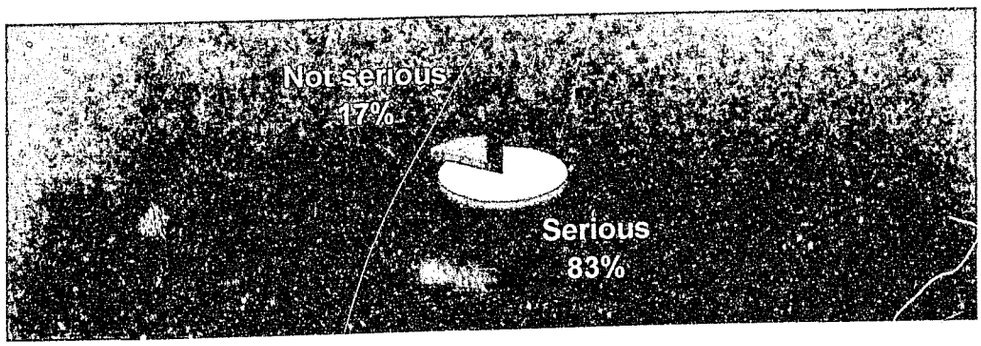
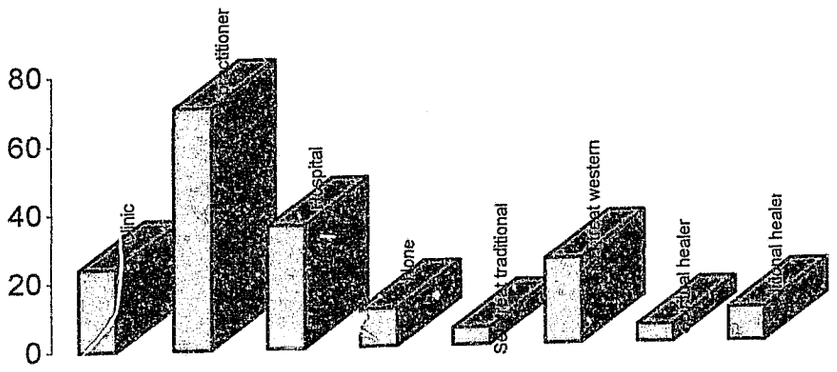


The high number (83%) of people who think that their illness is serious is likely to influence their illness behaviour.

Perceptions on seriousness of illness are usually influenced by community held beliefs and the expectations of the sufferer, particularly possibilities of available care and sympathy (Helman, 1984). Interviewers also establish a relationship with respondents which, can influence how they reveal their pain and suffering (Helman, 1984). The use of allopathic care givers as interviewers is also likely to contribute to the deference effect on the responses (Fowler, 1995).

The behavioural pattern of the residents of Daveyton in seeking the initial help for their illnesses is illustrated in figure 6.

Figure 6. First help sought for illness (number per type).



The general practitioners were by the far the most frequently consulted (38.0% - 71) of any of the other providers of service. The hospital at (19.3% - 36) was the next frequently

used service followed by self-treatment with western type medicines which is 13.4% (25). The clinic was at 12.8% (24). A total of 70.1% people sought help from the formal health care system and if we take self-treatment with western medicines we arrive at a total of 83.5% of people that used a western type healing system for their illness. Traditional healers were used by 5.3% (10) of the population under study. The least used healing systems were spiritual healers and self-treatment with traditional medicines, both stood at 2.7% about 5 in number. Those that chose not do anything about their illness were 5.9% (eleven in total).

Contrary to expectations the consultation pattern on first help sought did not show any distinct pattern when compared with the joint household monthly income, family size and the type of dwelling as illustrated in tables 11 to 13.

Table 11. Household monthly income (R) and first help sought.

Income	Clinic	GP	Hospital	None	Selftreat Tradition	Selftreat Western	Spiritual healer	Traditional healer	Total
<500	11	20	9	2	3	4	2	1	50
501-1000	6	22	12	2	1	8	2	3	56
1001-2000	7	13	7	3	1	4	1	4	39
2001-3500	0	7	5	3	0	3	0	2	20
>3500	0	9	3	1	0	6	0	0	19
Total	24	71	36	11	5	25	5	10	187

An expected value is < 5. Chi square not valid. Chi square = 24.30
Degrees of freedom = 21. P value = 0.27891408.

Table 12. Family size and first help sought.

Family size	Clinic	GP	Hospital	None	Selftreat Tradition	Selftreat Western	Spiritual healer	Traditional healer	Total
1 to 3	11	24	10	6	2	6	1	3	63
4 to 6	7	37	20	1	1	16	3	5	90
7 to 9	5	7	4	2	1	2	1	1	23
> 10	1	3	2	2	1	1	0	1	11
Total	24	71	36	11	5	25	5	10	187

An expected value is < 5. Chi square not valid. Chi square = 20.86
Degrees of freedom = 21. P value = 0.46776351

Table 13. Type of dwelling and first help sought.

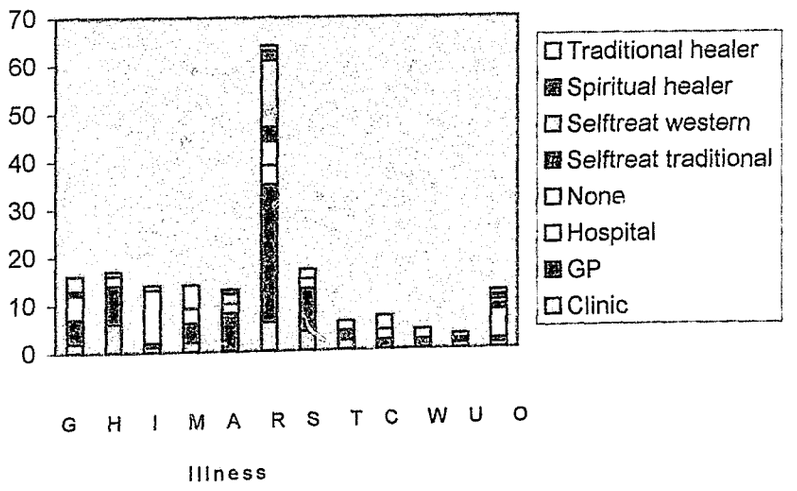
Dwelling type	Clinic	GP	Hospital	None	Selftreat Tradition	Selftreat Western	Spiritual healer	Traditional healer	Total
Informal	9	12	6	3	3	5	3	3	44
Modern	2	16	13	4	0	12	0	3	50
Low cost	1	6	1	1	0	0	1	0	10
Council	11	31	16	3	2	7	1	4	75
Other	1	6	0	0	0	1	0	0	8
Total	24	71	36	11	5	25	5	10	187

An expected value is < 5. Chi square not valid. Chi square = 36.52
Degrees of freedom = 28. P value = 0.12984162.

Tom (1992) also did not find any socio-economic differences in the use of traditional healers by the urban and rural Transkeians. In its South African Health Review, the Health Systems Trust (1999) found a high use of services of private providers across all income groups in urban areas. There was also a significant use of private providers by low income groups in rural areas. Both these studies do not show a distinct consultation pattern of black persons related to socio-economic factors.

There was a discernible relationship between choice of first help sought and type of illness as illustrated in figure 7. The general practitioner is consulted more frequently for respiratory problems, which are the most frequent complaint and are generally easily manageable in this setting. The hospital on the other hand is the first choice for injuries. Self-treatment with western medicine is used more frequently for respiratory conditions. Of the four people who believed they were bewitched 2 consulted a traditional healer and the rest went to hospital for assistance. Equal numbers of those that had tuberculosis consulted the clinic, general practitioner and hospital.

Figure 7. Type of illness and first help sought.



G:Gastrintestinal	H:Hypertension	I:Injury	M:Mental illness
A:Musculoskeletal	R:Respiratory	S:Integumentary	T.Tuberculosis
C:Headache	W:Witchcraft	U:Unknown	O:Other

A total of 58.3% of respondents were satisfied with the assistance they received from the first help sought, while 41.7% were not entirely satisfied. Their responses ranged from being very unhappy to being uncertain about the quality of the service. Table 14 maps out the satisfaction according to care giver consulted.

Table 14. Satisfaction with first help sought.

Satisfaction	Clinic	GP	Hospital	None	Selftreat Tradition	Selftreat Western	Spiritual healer	Traditional healer	Total
Yes	14	50	21	2	1	13	4	4	109
No	10	21	15	9	4	12	1	6	78
Total	24	71	36	11	5	25	5	10	**187**

An expected value is < 5. Chi square not valid. Chi square = 17.34
Degrees of freedom = 7. P value = 0.01530840.

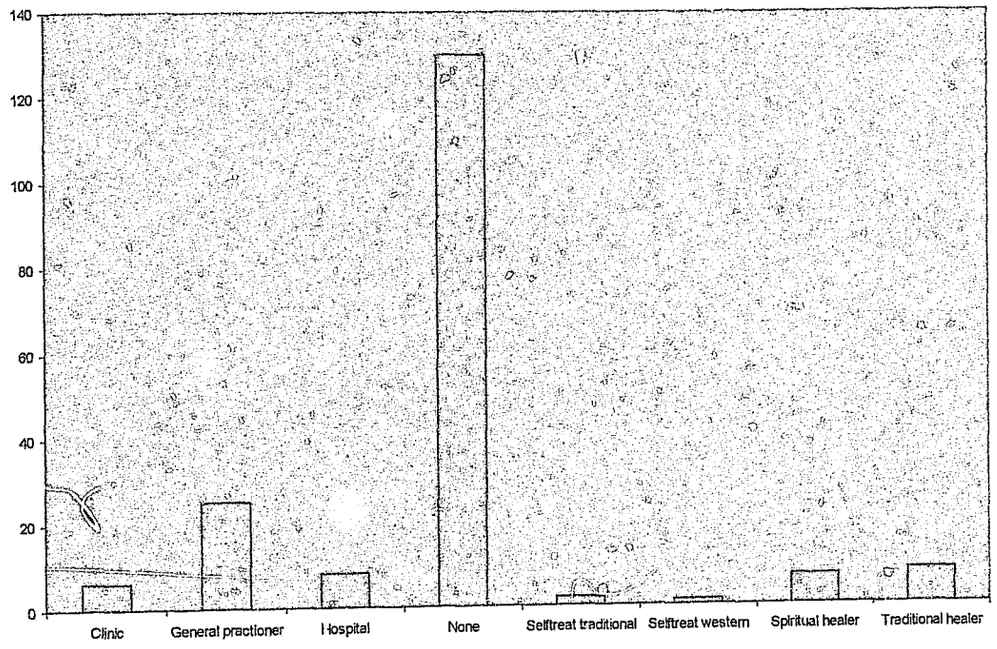
Those that visited a general practitioner were most satisfied with the assistance received at 70.4% and were followed by the clinic and the hospital at both 58.3%.This pattern is corroborated in the study done by the Health Systems Trust (1999) in the Eastern and Western Cape on why low income groups use the private doctors. The reasons given were easier access, longer hours of service, shorter waiting times, being seen by a doctor (as opposed to a nurse), more personalised attention and the perceived better quality of

care. The number that visited the spiritual healer was small (only 5) and the 80.0% satisfaction may not tell us much. It is interesting to note though that out of the 10 that visited the traditional healer, only 40.0% were satisfied with the help received. Satisfaction with self-treatment with western medicines was 52.0% (13 out of 25) and only 20.0% (1 out of 5) with traditional medicines. People who did nothing about their illness were least satisfied (18.2%), mainly because some had limited choices as a result of financial constraints.

The general practitioners see 43.9% (25) of the 57 people who seek second help, which is only 30.5% of those who sought first help but also include those who did nothing (5.8%) about their illness. Traditional healers see 14.0% while spiritual healers see 12.3%. Self-treatment with western medicine is not a favoured choice of second help. It is the lowest at 1.7% (1), followed by self-treatment with traditional medicine at 3.5% (2). The clinic and the hospital see 10.5% (6) and 14.0% (8) consecutively. Consultation patterns follow by and large the earlier trend with the GPs being the most utilized provider of service with the exception that the traditional and spiritual healers are seeing a significantly much larger percentage than in the first help sought. It is possible that lack of adequate explanation about illness as well as less well defined illnesses in terms of the biomedical

model like psychosomatic disorders and mental illness will lead patients to seek help from these alternative providers of care.

Figure 8. Second help sought for illness (number and type).

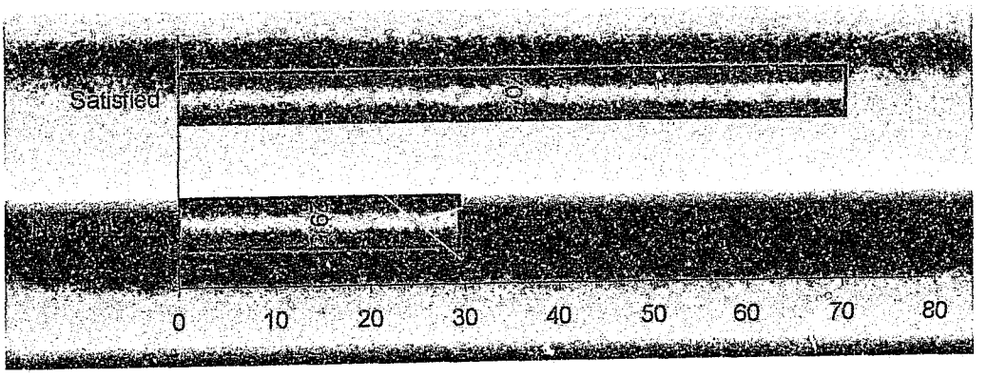


The level of satisfaction with the second help was higher at 70.5% as opposed to 58.3% satisfaction with the first help (p value = 0.03768961) as illustrated in figure 9.

It would appear that an overwhelming number of people are satisfied with their second choice help. The level of satisfaction was high with all the different health care providers including traditional and spiritual healers. It is not

clear what the reasons are. There is a possibility of getting better over time due to the natural progression of an illness as well as a possibility that there might be greater acceptance of a condition if confirmed by a second opinion. Attitudes and expectations of a particular healer or method of treatment can also influence a patient's feeling about his/her experience of the treatment received from the healer (Helman, 1984).

Figure 9. Satisfaction with the second help sought (%).



Most of the other parameters compare with those of the first visit especially when it comes to satisfaction according to sex; consultation patterns according to occupation, illness, type of dwelling and family size.

Based on their experience people indicated their preference for the next help they would prefer to seek in future according to the table 15.

Table 15. Preferred next help.

Next Help	Frequency	Percent
Clinic	23	12.3%
General Practitioner	92	49.2%
Hospital	27	14.4%
Self-treat traditional	1	0.5%
Self-treat western	4	2.1%
Spiritual healer	6	3.2%
Traditional healer	6	3.2%
Uncertain	28	15.0%
Total	187	100.0%

General practitioners appear to be the most preferred provider of healthcare if people had their choice. A large majority at 49.2% (92) would choose a general practitioner when they next experience an illness. A substantial number would use the hospital (14.4%) and the clinic (12.3%). This brings the percentage of those who choose to use a formal health care system to 75.9%. However, a significant number

(15.0%) is undecided about the choice of help they would seek in future. Only 3.2% would visit a traditional healer; and the same percentage would seek help from a spiritual healer. Even less would use self-treatment with western medicines (0.5%) and 2.1% with traditional medicines.

The low number that seeks help from traditional healers is in contradiction with most literature. Our questionnaire had asked respondents about what they do when they experience illness or injury and it is not surprising in this particular study that the number is low as traditional healers were the least sought help for the first visit. However, it is possible that had questions been asked in another way, a different response could have been elicited. Tom (1992) had asked if people had ever visited a traditional healer in their lives, while the study by the Department of Sociology, University of Witwatersrand, had only asked respondents about their consultations patterns for their everyday illnesses (Morris, 1999). It is also possible that traditional healers are mostly consulted for what might not be defined as an illness in western medical terms. These could be misfortune blamed on witchcraft, relationship problems and feelings of guilt about not observing cultural practices as well as for routine rituals during certain life stages like birth and death in the family (Mhlanga, 1999).

Another reason for the low figure could be the dominant role that the biological model plays in the lives of people in a urban township. It is the only legally sanctioned method of healing and has become part of their lives from early infancy when every child in the Greater Benoni area is immunized and successful immunization campaigns are run where 87% of the target population is covered (Selahle, 2000). The biomedical model of care is actively encouraged with financial capital behind such promotion resulting in medicalisation (increasing medical definition and jurisdiction over more and more areas of life) of society (Hillier, 1986).

Qualitative data.

The qualitative data obtained from the open ended section of the questionnaire on help seeking behaviour were grouped into various themes, five of which were clearly identifiable – perceptions on well-being, seriousness of illness, general complaints about services, some reasons for consulting folk healers and how they relate the stories on treatment received.

Perceptions on well-being.

Most people in the survey defined well-being as a state when a person is able to do what he/she is normally able to do like household chores, recreation and going to work. A child must be seen playing as normally as before the illness started. This definition of health which emphasizes functionality is quite realistic in contrast to the World Health Organization's (WHO) definition which states that 'health is a state of complete physical and mental well-being and not merely the absence of disease or infirmity.'

Seriousness of illness.

Respondents put reasons like pain and discomfort, vomiting, loss of appetite, loss of weight, and sleeplessness to support their view of the seriousness of illness. Need for hospitalization was regarded as meaning that the illness is serious. Diseases like hypertension, diabetes and asthma even though the condition was diagnosed for the first time and the patients were without symptoms, were taken seriously by the respondents. Potentially disfiguring afflictions of the skin, all types of injury and illnesses that took long to heal were regarded as serious as well. The recognition and experience of illness is defined by the norms and values

prevalent in that particular society or community (Gilbert, Selikow & Walker, 1996).

General complaints about services.

In the open ended questions complaints about services emerged and were mostly directed at the public facilities especially local clinics. Respondents felt there were not enough facilities, existing facilities were not accessible, had poor perceived quality of service, opening hours were not convenient, there is poor attitude of staff and sometimes lack of medicines. This perception is supported by the findings of the (SAHR) South African Health Review (1999) in the Eastern and Western Cape. The private providers were slated for their exorbitant fees and a business like approach to their illness. One respondent said, 'GPs are all about making money for themselves rather than helping us.' There was also complaints about the high cost of prescription medicines.

Reasons on consulting folk healers.

When an illness was less well defined it was most likely that a traditional or spiritual healer would be consulted. One respondent who developed an athralgia (painful joints) of both feet, decided to seek second help from a traditional healer

because she believed that her illness was 'invisible' to the medical practitioners who had earlier treated her. Underlying belief systems will also determine the person's response to an experience of illness (Gilbert, 1996). Another respondent whose father is an evangelist said, '.....when illness strikes all I do is call upon the name of Jesus and curse the demons.'

How they relate stories on treatment.

The whole experience of illness was both unpleasant and frustrating for a few respondents. Limited choices imposed by lack of money led to a sense of helplessness for some. The clinic was generally used not out of choice for many. On the other hand, the GP was used by some people who did not really believe that they would receive appropriate help from them. It is likely then that the private GP surgery has become institutionalized in the lives of the people of Daveyton and is used by all income groups (SAHR).

Blame, anger and denial were part of the natural response to the unpleasant news. Medical personnel were the natural scapegoat. One respondent whose three year old child developed status asthmaticus (severe acute attack of asthma) at home, blamed the doctors for not picking it up at birth. Another respondent whose child had a severe allergic

reaction to eggs, doubted the medical diagnosis as her child had always eaten eggs in the past. There was also blame on culturally defined symptom complexes like *isidliso* (a belief that certain illness are caused by some poisonous substance ingested), *inyongo* (gastrointestinal but sometimes a range of other vague illnesses like headache and dizziness believed to be caused by a 'dirty' stomach – remedies involve purgatives, induction of vomiting and enemas), *ukumilisa* (a range of practically any childhood illness believed to be associated with teething) and *inyoni* (a belief that an infant would be sick unless an enema is given for the first stool) for the illness experienced (Mhlanga, 1999).

SUMMARY

The study was aimed at determining the utilisation patterns of the different healing systems that are found in the black township of Daveyton. Even though no assumptions were made, literature pointed out to traditional African medicine as a dominant form of care among black people in South Africa as well as the rest of the African continent.

While it is estimated that 70 to 80% of the black population in this country would use traditional healers, some studies have

put this figure to as low as 1.5%. It is important to note that the studies have differed greatly in their design and the specific black population studied. In this particular study respondents were asked to tell their own story of a recent experience of illness. The finding of a rate of 5.3% for a visit to a traditional healer is actually higher than other urban areas with similar socio-economic characteristics like the study done by the Department of Sociology, University of Witwatersrand, on a Survey of Soweto in the late 1990s. A total of 1.5% of Sowetans report consulting traditional healers for their illness. A very low reliance on self care with traditional medicines which is at 2.7% was also an unexpected finding in this study. In a study done by Tom (1992) in the Eastern Cape in the urban and rural catchment areas of Umtata hospital for his research report for Master of Family Medicine, University of Witwatersrand in 1990, 73.5% of respondents had used a traditional healer in their lives. The number that used a traditional healer for a second opinion rose almost threefold to 14.0% which, shows that there is greater reliance on alternative medicine when orthodox medicine does not offer ready answers. This has serious implications for illnesses like HIV/AIDS and tuberculosis.

The western type of health care was used far more frequently with the general practitioners used most frequently, even more than the clinics – 38.0% for GPs compared to 12.8% for the clinic and 19.3% for the hospital. The clinics in Daveyton are few (6 in total including two large medical centres) and open on less convenient hours, while there are an estimated 30 general practitioners, many of whom opening till late and on weekends (Selahle, 2000). There is one facility jointly run by the doctors' Independent Practitioners' Association opening 24 hours a day all seven days of the week. A managed care facility offering budget consultation fees was also counted among general practitioners even though sometimes nurse practitioners see the patients. It is possible that this has inflated the number of people who consult GPs. The dominance of GPs in the lives of the people in Daveyton is also reflected in the second help sought (43.9%) and the preferred future help (49.2%). It was interesting to note that people indicated that they would visit a general practitioner even if they actually do not have much confidence in them. The South African Health Review (1999) study showed that in the treatment of sexually transmitted diseases only 23% of GPs effectively treated urethral discharge as compared to 82% of nurses at the clinic and with genital ulcers it was 15.5% and 72% respectively. One of the reasons was that doctors were unwilling to give expensive treatment to patients

who are unable to pay for it. This study shows that the management of illness is not necessarily better in the private sector but the perceived quality of care draws patients away from the public health facilities towards the private sector.

The high number of self-treatment with western medicine (13.4%) swelled the reliance on western type of care to 83.5%. This number may reflect readily available medicines (self purchased or prescription medicines) because of the dominance of allopathic medicine.

Spiritual healers were not used that frequently, but the number used for second visits was 12.3% which, was four and half times the number for the first visit (2.7%).The lay referral system was not seen to be operating. Other Asian or western type of alternative medicine did not feature at all.

While there was a demonstrable relationship between certain socio-economic variables like joint household monthly income and type of dwelling (p-value = 0.0000) as well as occupation of respondent and type of dwelling (p-value 0.0000), there was no relationship between either joint household income (p-value = 0.2789) or family size (p-value = 0.4678) and choice of first help. This study corroborates the finding of the South African Health Review of the use of the private sector care

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across all income groups in the urban areas and less by the low income groups in the rural areas. In Tom's study (1992) in rural and urban Trankeians around Umtata their high use of traditional healers did not show any socio-economic differences.

Persons with injuries were most likely to be taken to hospital directly. This may be due to efficient emergency services in the area and the priority they normally give to injuries especially motor vehicle accidents.

While the qualitative findings may not necessarily hold true beyond the field of this study, it is interesting to note how people perceive the services and react when they experience illness. It is quite clear that the clinic is viewed as a needed service but inaccessible in terms of geographic distance, long waiting hours, inconvenient opening hours, unavailability of medicines and unfriendly staff. The same findings are confirmed by the SAHR (1999).

If we understand what symptoms patients regard as most serious when their ill, it would help in compliance when these are addressed. The knowledge of illnesses that traditional healers are most likely to see will help in future public health planning when cooperation with them is enlisted.

CONCLUSION

This study conducted in an urban area showed a heavy reliance on orthodox medicine and much less than expected use of alternative traditional medicine for the health care needs of a population in the black township of Daveyton. This trend was not influenced by any differences in the socio-economic status of the population under study. The public facilities especially the clinics were used much less with perceived poor quality of service cited as the main reason while the general practitioners were perceived to provide a better individualized quality of care. The true extent of the use of traditional healers may not have come out (Morris, 1999) because of the reluctance of people to talk about it especially when interviewers are perceived to be coming from the health care sector.

It is hoped that this study will be of some use in public health planning for developing policy and provision of health care in black urban areas. The experience of illness in a family is not a pleasant one and the health care system can do a lot more to ameliorate the sense of frustration and helplessness.

Further studies among homogenous groups and specific to particular regions are needed to be able to measure the true extent of use of alternative health care systems by the black community in South Africa.

Appendix 1.

Worksheet

Name of Interviewer:

Questionnaire Numbers										

(In/Out/Refused/Accepted)

Address visited	Outcome of visit	Questionnaire No.

Notes

_____

_____

Appendix 2

Consent Form

A study on the utilisation pattern of the healing systems by the residents of Daveyton done in the month of July 2000.

Dr. M Dlamini, Pr .. L Gilbert (Research Supervisor)
University of Witwatersrand, Community Health Department

This study which is for a higher degree at the University of Witwatersrand is looking at finding out what kind of help the people of Daveyton seek when they are ill.

Questions about your age, sex, income, employment, education, and illness will be asked.

You are not compelled to participate in the study. But, if you do that will help us gather information which will be of great assistance in planning for health services. There is no direct benefit for you as an individual.

The things you tell us are not going to be known by anyone else.

The University of Witwatersrand Ethics Committee has approved the research and it is for the degree of Master of Public Health.

Informed verbal consent obtained / refused.

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Questionnaire

Questionnaire ID	

A. Personal Characteristics of the Respondent

1. How old are you?

<20	1
20 - 29	2
30 - 39	3
40 - 49	4
50 - 59	5
60 - 69	6
>70	7

2. (*The sex of the respondent will be noted and recorded into the two categories below*).

M	1
F	2

3. What is your marital status? (*Interviewers will be asked to prompt for other forms of arrangements where men and women live together*).

Married	1
Single	2
Divorced	3
Other (specify)	4

Specify other_____

4. What is your status in the family?

Mother	1
Father	2
Grandmother	3
Grandfather	4
Student	5
Other (specify)	6

Specify other_____

B. Socio-economic Variables

5. *(The type of dwelling and environment will be observed and noted below).*

Informal Housing	1
Old Council Houses	2
Modern House	3
New low cost housing	4
Other (specify)	5

Specify other_____

6. What is last standard you passed at school?

7. Did you do any training after leaving school?

Specify_____

8. What kind of work do you do?

Specify occupation_____
If the answer is "none".

Do you do any work from home or on the street.

Specify occupation_____

9. What is the source of your household income?*(More than one category could be checked)*

Formal Employment	1	Self Employment	3
Informal Employment	2	Other	4

Specify other_____

10. What is the joint household income per month (*in Rands*)?

less than 500	1
501 - 1 000	2
1 001 - 2 000	3
2 001 - 3 500	4
more than 3 501	5

11. How many family members live in the house?

1 to 3	1
4 to 6	2
7 to 8	3
>10	4

12. How many families live on this particular stand? (*This relates to subtenants who are not necessarily related to the landlord*).

1
2
3
4+

C. Questions on help seeking behaviour

13. When was the last time someone in this family was ill? *If it falls in the last 12 months, that's OK. If it doesn't ask:* Was no one sick more recently than that? (*Only one family member's illness is recorded. Interviewers will ask for specific symptoms and will record all responses in whatever way it is presented by the respondent)* ***Probe for symptoms.***

a) What was wrong with...?

_____

b) What do you call that illness?

_____

_____

c) Characteristics of person with illness

Age	
Sex	
Family Status	
Educational level	
Occupation	

14. Did you think that the illness was serious? (*All responses acceptable)*

_____

_____

15. *(Interviewers to take respondent step by step through their illness and listen patiently to their illness stories).*

a) What did you do when you first got sick or were injured?

_____

_____

b) And then what did you do?

_____

_____

c) And then what happened?

_____

_____

d) What did they do for you at....?

_____

_____

e) Were you satisfied with that?

_____

_____

f) And then what did you do?

_____

_____

g) And what did you feel about that?

_____

_____

h) What will you do next time you are sick/injured?

_____

_____

(Questions will be asked until respondent has told his/her illness story?

Appendix 3

Figure A. Area with modern houses



Figure B. Area with informal type houses

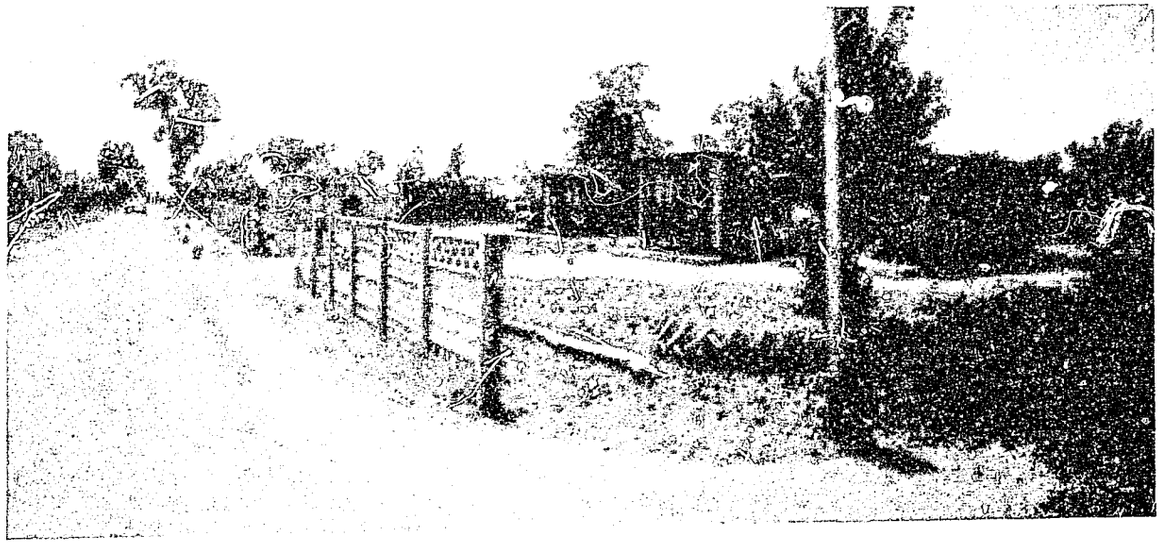

Figure C. Old council houses.



Figure C shows the existence of many modern houses among the old council houses.

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Dlamini

CLEARANCE CERTIFICATE **PROTOCOL NUMBER** M990911

PROJECT A Study of The Factors That Influence A Person's Choice Of Any Available Alternative Healing Systems In The Township Of Daveyton

INVESTIGATORS Dr M Dlamini

DEPARTMENT Community Health Dept. Wits Medical School

DATE CONSIDERED 991001

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 991004 **CHAIRMAN** ..... (Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Dr L Gilbert
Dept of Sociology Department, Wits University

Works2\sln0015\Hum5th97.wdb\M 990911

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE 30/9/99 SIGNATURE .....

PROTOCOL NO.: M 990911

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Author Dlamini M
Name of thesis The Utilisation Of Different Healing Systems By The Residents Of Daveyton Township On The East Rand Dlamini M 2000

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