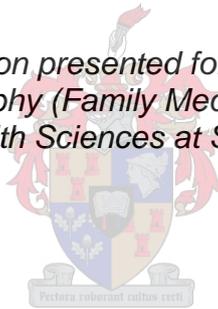


**EXPLORING THE HEALTH KNOWLEDGE CARRIED BY  
OLDER XHOSA WOMEN IN THEIR HOME SITUATION, WITH  
SPECIAL FOCUS ON INDIGENOUS KNOWLEDGE**

by

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## ABSTRACT

**Rationale:** Critical questions have been raised about the overcrowding of primary care services, such as community health centres (CHCs) and clinics in predominantly Xhosa-occupied areas in the Western and Eastern Cape, with clients who present with minor health ailments. Suggestions have been made about the integration and the use of the indigenous health knowledge (IHK) carried by older Xhosa women in the services as a strategy for managing minor health ailments, and as a way of encouraging appropriate health-seeking behaviour. Preliminary studies have reinforced the need for the revival of the IHK that currently is lying dormant within communities. The studies affirm that such knowledge could be an asset if integrated into, and valued by, the Western biomedical model, and could play a major role in contributing towards alleviating the problem of overcrowding in primary care (PC) services.

**Aim:** This study primarily explored and described the IHK carried by older Xhosa women and used in the management of health problems in their home situation. Secondary recommendations were made to key stakeholders regarding the use, retainment and integration of the IHK into PC services.

**Method:** This ethnographic, feminist and emancipatory study used qualitative methods of data collection. Thirty-six (36) older Xhosa women were purposefully selected to participate in four FGDs, to explore the IHK that they used for managing health problems in their home situation. Sixteen (16) in-depth interviews were conducted with the elite older Xhosa women and their family members to validate the findings from the four FGDs. The process of analysis and interpretation was informed by an inductive process of a combination of narrative analysis and the analysis of narratives strategies.

**Findings:** The findings showed that the older Xhosa women possess IHK regarding the management of minor health problems within the home situation. Assessment, treatment strategies and medications were identified. Functionality and observation are mainly used to diagnose and manage illness. This approach also includes monitoring the progress, severity and recovery from illness in the patient. The findings further demonstrated that older Xhosa women were also managing illnesses that could be classified as major. They could clearly distinguish between what was health and what was illness in their village. Distance from health care services had an impact on the health-seeking behaviour of the older Xhosa women, with those closer to health care services wanting all illnesses, even those that could be classified as minor health ailments, to be managed by the health service, and those who

were farther away from the hospital appearing to manage complex illnesses, and only referring clients with those illnesses to external health care services quite late. The findings further showed communication and attitudinal problems that existed between the clients and health care providers.

**Conclusion:** Many studies have already challenged the manner in which PHC was implemented in developing countries, as it appeared to focus on the curative approach to disease and left out disease prevention and health promotion. It is within this area that the older Xhosa women appear to express the greatest concern for the health of their homes and villages. The older Xhosa women in the Eastern Cape appear to be struggling with problems of broken family units, and are left behind to struggle to keep the home together, as they lack the necessary resources to do the hard work involved with producing food and building the home and village.

In the light of the promise of National Health Insurance and the revitalisation of PHC, the study proposes that the two major national health policies should take cognisance of the IHK utilised by the older Xhosa women, and that there should be a clear plan as to how the knowledge can be supported within a health care systems approach. A rural health model is proposed by the study to do this.

**Keywords that underpin the core objectives of the study**

Indigenous health knowledge (IHK), older Xhosa women, home management of health problems, minor health ailments, major health problems, primary level of health care.

## OPSOMMING

**Rasionaal:** Daar word kritiese vrae gestel oor die toeloop van mense met geringe ongesteldhede by primêre-sorg(PS)-dienste, soos gemeenskapsgesondheidsentrums (GGS) en klinieke, hoofsaaklik in Xhosa-woongebiede in die Wes- en Oos-Kaap. Voorstelle is geopper dat ouer Xhosa-vroue se inheemse gesondheidskennis (IGK) by die dienste geïntegreer en benut moet word as 'n strategie om minder ernstige gesondheidsprobleme te bestuur en om mense aan te moedig om toepaslike keuses oor gesondheidshulp te maak. Voorlopige navorsing het die noodigheid bevestig dat die kundigheid wat tans onbenut in gemeenskappe lê, herontgin behoort te word. Die navorsing bevestig dat sulke kennis 'n bate kan wees indien dit as 'n gewaardeerde element by die Westerse biomediese model ingeskakel word en dat dit 'n groot rol kan speel om die druk op PS-sentrums te verlig.

**Doelstelling:** Hierdie navorsing ondersoek en beskryf hoofsaaklik die IGK waaroor ouer Xhosa-vroue beskik en wat in die hantering van gesondheidsprobleme in hul tuisomgewing aangewend word. Aanvullende aanbevelings rakende die gebruik, behoud en integrasie van IGK by PS-dienste is aan bepalende belanghebbers voorgelê.

**Metode:** Kwalitatiewe data-insamelingsmetodes is in hierdie etnografiese, feministiese en bevrydingsgerigte navorsing gebruik. Ses-en-dertig ouer Xhosa-vroue is spesifiek uitgesoek vir deelname aan vier fokusgroepbesprekings (FGB's) om hul hantering van gesondheidsprobleme in hul tuisomgewing aan die hand van hul IGK te ondersoek. Sestien indringende onderhoude is met die elite- ouer Xhosa-vroue en hul gesinslede gevoer om die bevindings van die vier besprekings te bevestig. Die proses van ontleding en vertolking is gerig deur 'n induktiewe proses wat 'n kombinasie van narratiewe ontleding en die ontleding van narratiewe strategieë behels het.

**Bevindings:** Die bevindings wys dat ouer Xhosa-vroue IGK het rakende die hantering van minder ernstige gesondheidsprobleme in die tuisomgewing. Evalueringsmetodes, behandelingstrategieë en medikasie is uitgewys. Kwale word hoofsaaklik volgens funksionaliteit en waarneming gediagnoseer en hanteer. Die werkwyse sluit in dat pasiënte se vordering, die erns van hul siekte en hul herstel gemoniteer word. Die bevindings wys verder dat ouer Xhosa-vroue ook siektetoestande hanteer wat as ernstig geklassifiseer kan word. Hulle kan duidelik tussen gesondheid en siekte in hul gemeenskap onderskei. Die afstand vanaf gesondheidsorgdienste speel 'n rol in die gedrag van ouer Xhosa-vroue wat keuses oor gesondheidshulp betref; diegene wat na aan 'n gesondheidsorgsentrum woon, verkies dat die gesondheidsdienste alle siektes - selfs dié wat as minder ernstige

gesondheidskwale geklassifiseer kan word - moet hanteer, terwyl diegene wat verder van 'n hospitaal woon, klaarblyklik self komplekse siektetoestande behandel en eers op 'n gevorderde stadium sulke kliënte na eksterne gesondheidsorgdienste verwys. Die bevindings het ook probleme rakende kommunikasie en houdingsingesteldheid tussen kliënte en gesondheidsdiensverskaffers uitgewys.

**Gevolgtrekking:** Verskeie ondersoeke het al die manier waarop PG-sorg in ontwikkelende lande toegepas word, bevraagteken, aangesien die benadering oënskynlik op genesing fokus terwyl dit siektevoorkoming en gesondheidsvoorligting verontagsaam. Dis oor hierdie aspek dat die ouer Xhosa-vroue skynbaar die grootste kommer oor die welstand van hul huishoudings en gemeenskappe het. Die ouer Xhosa-vroue in die Oos-Kaap het klaarblyklik met dieselfde probleme van gebroke gesinne as dié in die Wes-Kaap te kampe, en word dikwels alleen agtergelaat om die huishouding te laat oorleef. Hulle kry swaar om sonder die nodige hulpbronne die harde werk te doen om voedsel te produseer en om huishoudings en die gemeenskap op te bou.

In die lig van die vooruitsigte wat nasionale gesondheidsversekering en vernuwing van die PGS inhou, stel hierdie navorsingsprojek voor dat bogenoemde twee hoofelemente van die nasionale gesondheidsorgbeleid aandag skenk aan die IGK wat ouer Xhosa-vroue toepas, asook dat 'n duidelike plan uitgewerk word oor hoe hierdie kennis binne die benadering tot gesondheidsorg ondersteun kan word. Die navorsings stel 'n model vir plattelandse gesondheidsorg voor om dié doelstellings te verwesenlik.

**Sleutelbegrippe wat die kerndoelstellings van die navorsingsprojek onderlê**

inheemse gesondheidskennis (IGK), ouer Xhosa-vroue, tuisbestuur van gesondheidsprobleme, minder ernstige gesondheidskwale, ernstige gesondheidsprobleme, gesondheidsorg op primêre vlak

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**LIST OF ABBREVIATIONS**

ANC	African National Congress
CHC	community health centre
CBE	community-based education
CNP	clinical nurse practitioner
FFF	family planning, female education, and food supplementation
FHS	Faculty of Health Sciences
FG	focus group
FGD	focus group discussion
GOBI	growth monitoring, oral rehydration therapy, breastfeeding and immunisation
GP	general practitioner
HIV	human immunodeficiency virus
ICF	International Classification of Disease, Health and Functioning
IHK	indigenous health knowledge
IMR	infant mortality rate
IP	indigenous people
MMR	maternal mortality rate
MRC	Medical Research Council
NCCAM	National Centre for Complementary and Alternative Medicine
NGO	non-governmental organisation
NHI	National Health Insurance
NRF	National Research Foundation
PC	primary care
PHC	primary health care
RDP	Reconstruction and Development Programme
SU	Stellenbosch University
STD	sexually transmitted disease
TB	tuberculosis
TOC	transitional opportunistic converser
UCT	University of Cape Town
UNICEF	United Nations Children's Fund
U5MR	under-5 mortality rate
USA	United States of America
UWC	University of the Western Cape
WHO	World Health Organisation

## THE USE OF TERMINOLOGY IN THE STUDY

### **Critical incidents**

Miles and Huberman (1) describe critical incidents as events that have strong catalytic effects. The events are decisive and influence conduct and approaches. Rubie and Babbie (2) define a critical incident as one in which something of special importance seems to happen, which is either positive or negative, and which might offer valuable new insights into how a practice can be improved. They further suggest that direct service practitioners could be asked to identify cases that, in their judgment, turned out to be their best success or their worst failure. For this study, use of the term 'critical incident' will relate to difficult and complex health problems that require critical and, in some instances, fast response from the older Xhosa women in a village setting. During the incidents, the skills of the elite older Xhosa women, in particular, might be required.

### **Elite groups**

Elite groups are composed of influential, prominent and well-informed people, who occupy important positions and whose behaviour is associated with those positions. They are expected to hold a basis of expertise, valuable information and an overall view of the social organisation in their villages. Elite groups of people respond to questions about broad areas of content and display a high degree of intelligence. For this study, the elite older Xhosa women are renowned in their villages for their IHK. (3,4)

### **Feminist and emancipatory schools of thought**

Feminist studies are emancipating, as they are critical ethnographic studies that have advocating agendas and that are intended to "challenge the legitimacy of the male dominant order... (and to) ... turn critical thought into emancipating action". (4) In this study, the perceptions of the healing features of indigenous knowledge that had been erased from conscious memory or repressed into the subconscious of its carriers, but which survives on a preconscious level will resurface in the realm of the conscious through the use of an ethnographic methodology, thus becoming emancipated. (4,5,6)

### **Indigenous health knowledge (IHK) carried by older people**

Indigenous knowledge consists of community knowledge, skills, attitudes, values and technologies that pervade, or are endemic to, a particular community. (3,7) Mishra, Hess and Luce (8) emphasise the use of the correct terminology when conducting indigenous knowledge systems studies. They opt to use the term 'indigenous', rather than 'native' or 'traditional', as is often found in the literature, because it more accurately represents the practitioner's use of IHK. Aside from negative racial connotations, 'native' locates people in their land of origin and often does not apply to highly mobile people. 'Traditional' implies the holding of fixed beliefs handed down from the past, thus contradicting the idea of research, whereas 'indigenous' locates indigenous people and their indigenous knowledge systems within contemporary society. The term also acknowledges practices and a belief in culture and history, without inaccurately restricting such matters in time, space or extent. The conceptual underpinning of this research is based on the thinking that the IHK carried by the older Xhosa women is not restricted to time, space and extent, but keeps redefining itself according to the challenges and changes that each older Xhosa woman experiences in her home and in her rural environment. (8)

Relating to this study, IHK comprises the health knowledge (remedies and treatments) carried by the older Xhosa women. The IHK refers specifically to the local approaches, treatments, home remedies and strategies used by the older Xhosa women in managing health problems in their home situation.

### **Older women**

Louw, Van Ede and Louw (9), as well as Louw and Edwards (10) describe the stage of being an 'older woman' as being above 60 years of age. They further explain that this is the stage of life in which traditional values are upheld. In Xhosa, the women would be classified as *Makhulus*, in English as *grandmother*, and in Afrikaans as *Ouma*. For this doctoral thesis, the term includes *Makhulus* who do not have any grandchildren of their own. This is because, within Xhosa tradition, such women would still be expected to fulfil roles and responsibilities in line with those of older women who have grandchildren (as all children within a village belong to all the women in the village who are of childbearing age). (3) Thus, in the current study, the terms 'older Xhosa women' and '*Makhulus*' are used interchangeably.

### **Health problems**

Initially, this study aimed to explore minor health ailments. These are difficult to define, because often what at first sight appears to be minor can, at a later date and stage, develop into a major ailment. In Zonke's (3) study of IHK, older people came up with a long and exhaustive list of health ailments that they perceived could be managed at home. They were

unhappy with the suggestion that their management strategies were for minor health ailments only. They maintained that, when they were young, no distinction was made between minor and major health problems. The home was expected to manage all illnesses. The study sought to explore and to describe IHK and how it is practised by a specific group of older Xhosa women.

### **Home**

The home is classified as a complex terrain, in which closely-related family members live and interact, as well as serving as the locus of shared food and resources. It is seen as an organisational structure that is constructed around a certain hierarchy, and around certain interactions and organisational norms, often containing hidden aspects to its organisational life. Personal and private matters, such as illnesses, are declared in, and contained at home. (3)

### **Primary health care (PHC)**

PHC is a strategy that responds equitably, appropriately and effectively to the basic health needs of a group of people and which also addresses the underlying social, economic and political causes of poor health. It is underpinned by the principles of universal accessibility and coverage of the basis of need, with an emphasis on disease prevention and health promotion, community participation, self-reliance and intersectoral collaboration. (11,12)

### **Selective primary health care**

Selective PHC was an interim strategy that was used to begin the process of PHC implementation in developing countries. The focus was on four vertical programmes: growth monitoring; oral rehydration therapy; breastfeeding and immunisation (GOBI). Family planning, female education, and food supplementation (FFF) were added later. The interventions targeted only women of childbearing age (regarded as being 15–45 years of age) and children from birth through to age five. (12,13)

### **Primary care (PC)**

Primary care (PC) is the health care service that is made available as near as possible to where people live and work. It is enhanced by effective referral systems to more specialised levels of care. The Alma Ata Declaration calls for primary care to supply eight essential elements, including adequate food supply and proper nutrition, water and basic sanitation, as well as appropriate and acceptable health education. (13)

### **The backward and forward movement**

One of the key informants in this study, during community entry and the development of community partnership, recommended a development strategy to be used when a modern

concept has emerged. He said, before its implementation, that there was a need to connect the concept with the older traditional concepts to determine what should be integrated and what should be left behind, because of lack of relevancy to current development. The informant referred to this as '*the backward and forward movement*', and saw it as a way of eliminating gaps that undermine development. (14)

## **CHAPTER 1: INTRODUCTION**

### **1.1 INTRODUCTION**

The main premise of this doctoral study concerns the primary level of health care and the IHK possessed by older Xhosa women that remains dormant in the home, but which could be used as a strategy for managing minor health ailments in primary care (PC) services, as well as for encouraging appropriate health-seeking behaviour. Chapter 1 describes the emergence of the research question and presents an outline of important events that have influenced and placed this research within a participatory action research model. Through a bottom-up approach, using the methodologies of observation, consultation and discussion until a consensus was reached, key role-players assisted with the bringing to consciousness the possibility of the existence of IHK held by older Xhosa women in various rural villages.

In the evolution of the research problem (see Section 1.2) and in the motivation of this study (see Section 1.5), it is suggested that IHK lies dormant within communities that are serviced by overcrowded community health centres (CHCs) and clinics that are visited by a large proportion of clients who present with minor health ailments. It is postulated that this IHK could become an asset if integrated into, and valued by, the Western biomedical model utilised by these CHCs. The preliminary exploratory work which was undertaken as a basis to affirm this initial proposition was also used to identify the areas that required further and deeper exploration, as well as to draw boundaries in the study. Chapter 1 explores the complexity of the research question and the need to design a methodology that is encompassing and integrative enough to be able to reach valid conclusions.

### **1.2 EVOLUTION OF THE PROBLEM**

In this section, a brief overview is offered about the contextual factors which underpin the research question. The overcrowding of CHCs in Khayelitsha in the Western Cape, South Africa, as well as an overview of mini-epidemiological studies is presented and explained. An explanation of how community-based key role-players related to IHK – the older Xhosa women emerged – is also presented.

#### **1.2.1 The contextual factors**

Post-apartheid political change in South Africa, as brought about by the African National Congress (ANC) has had an important impact on the health system of the country. In 1996 PHC was adopted as a way to ensure equitable, accessible and affordable health care delivery. (15) The move was supported by the proliferation of clinics and CHCs. However,

despite this attempt to improve access to health care services, health care delivery in some areas remains predominantly characterised by overcrowding and prolonged waiting times for clients. (16) This situation results in client complaints about poor service and only brief encounters with doctors and hospital staff. There is often little opportunity for clients to express their own concerns. Sometimes clients are given medicine without any explanation as to the cause of the illness or a proper explanation of the effects of the medicine. (16-19)

A number of studies (16-19) have examined the health-seeking behaviour of clients attending CHCs, as well as the approach used to implement PHC in CHCs. These studies have concluded that various factors lead to overcrowding of CHCs and the health-seeking behaviour that is exhibited by their clients. Some researchers (17-19) have argued that, the overcrowded conditions are due to the majority of clients presenting with minor health ailments, and that this might be related to the free services provided at this level of care. Other researchers attribute the overcrowding to improved access to health services and to PHC. (17-19) It is this problem of overcrowding of the Khayelitsha (Western Cape) CHCs with some clients presenting with minor health ailments and the inadequate services that their clients complain about that gave rise to the evolution of the research problem for this doctoral study.

### **1.2.2 The overcrowding of CHCs in Khayelitsha, Cape Town**

CHCs in Khayelitsha are overcrowded with clients, a large number of whom are perceived as presenting with minor health ailments. Minor health ailments are defined as back pains, burns, colds, minor cuts, stomach-aches, insect bites, nosebleeds and rashes. (3,19,20) As a result of being overburdened with these health problems, health care professionals struggle to provide adequate attention and care to clients presenting with more serious ailments or to do community health education. (19-28) Little trust is built up between the health care providers and the clients because there is very little time to spend listening to the client's concerns, to alleviate fears and anxieties, or to provide clients with information or education. (15,19-21,25-28)

Mini-epidemiological studies were conducted in 2000 regarding clients who attended these CHCs. These studies showed that each CHC managed between 300 and 400 clients per day, the majority of whom were between 20 and 49 years old, and that 24-33% of these clients presented with minor health ailments. (19,20-21)

Similar studies were conducted in Khayelitsha by Cooper, Pick, Meyers, Hoffman, Sayed and Klopper (23) to determine the relationship between urbanisation, health status and the use of health services. These studies reported that 4.3% of clients presented with common acute

illnesses, such as abdominal pain, diarrhoea or gastroenteritis and vomiting, influenza and colds, upper respiratory tract infections, headaches and rashes. (22) The most common complaints were diarrhoea, abdominal pain and upper respiratory infections. The findings of Cooper et al (23) coincide strongly with the findings of Brice et al (20) and Keraan et al (21) Nsisi (24) conducted a study similar to Brice et al (20) and Keraan et al. (21) He tried to identify the top ten reasons for all client visits in Nolungile CHC (24) also in Khayelitsha. He found that these reasons included coughs, local erythema or rash, throat complaints, and back complaints, and included repeat visits for chronic diseases, such as hypertension, diabetes and epilepsy. Other studies by Nsisi (25) in Retreat CHC, Myburgh (26) in Eerste Rivier CHC and Loghdey (27) in a CHC in the Southern suburbs cited ailments similar to those of the previous studies of Cooper et al (23), Brice et al (20) and Keraan et al. (21)

### **1.2.3 The emergence of community-based key role-players to IHK: the older Xhosa women**

The problem of overcrowding at CHCs by clients, who appeared to be presenting with common or minor health ailments, was brought to the attention of various community health forums. These forums consisted of health care providers, elderly people in Khayelitsha, community health workers and students from the four Faculties of Health Sciences in the Western Cape, as well as their facilitators. (19-22) The forums acknowledged that the issue of health-seeking behaviour is complex and that there were a variety of reasons that influence clients to see the CHCs as an alternative to managing their own health ailments at home. (19-22)

The community health forums proposed that, *amongst other reasons*, it might be necessary to explore why there is a lack of knowledge about how to manage minor health ailments in the home. (19-22) They further suggested that because of the migration of young, rural people seeking urban work opportunities, it is assumed that there has been a breakdown in the family unit. (19-22) The experienced, older people who might have given these youth and young adults advice on how to manage health ailments in the home, may now be inaccessible to them, having either remained in the rural areas of the Eastern Cape or may be living in the older and more established Cape Town peri-urban housing estates of Gugulethu and Langa. (19-22) It was further assumed and suggested that there has been a shift from traditional home care to the Western biomedical model. (19-22)

Preliminary exploratory studies showed that clients were reluctant to mention other forms of care that they had tried before visiting the CHCs. (3,18,19) People appeared to become disempowered because of the way that health workers at the CHCs ignored and stigmatised the existence of any traditional knowledge of health care. (19,20,21) The community health

forums claimed that older people, who reside in Khayelitsha, specifically older women, are the carriers of this traditional knowledge. However, these women have a perception that the younger generation ignores their knowledge and they further assert that this problem is not only due to youth or generational challenges, but that the problem is also due to a shift in ideology from traditional home care to a Western biomedical model. (20,21)

In Mlenzana's (19) study on health seeking behaviour in clients attending site B and Michael Mapongwana CHCs, only 6% of older people who visited the CHCs presented with minor health ailments. Mlenzana (19) postulates that some older people living in Khayelitsha and Phillipi might still be using IHK. Zonke (3) a researcher who conducted a study on IHK for the management of minor health ailments in Khayelitsha supports this view, but raises concerns regarding the retention of this knowledge, as older people are dying out without having documented it. Recent years have seen traditional healers being recognised and collaborating with medical practitioners in managing primary health services. (29) However, there has been no acknowledgment of the role played by the older women in the care of health ailments within the home situation.

Some of the questions that were asked regarding the problem and as part of the process of creating some solutions were:

- a. Would it be more appropriate for clients to seek out the first-line practitioner in the home situation before seeking health care at CHCs?
- b. What happens in rural areas where CHCs/health workers are not readily available?
- c. Are there health resources, like IHK, lying dormant within the Khayelitsha community?
- d. Can IHK carried by the older people, specifically older women (*Makhulus*) be harnessed and used as *one* of the strategies to assist with the problem of overcrowding in CHCs? (19-21)

It was further suggested at the community health forums that awareness needed to be raised about the value of IHK, and that a partnership could develop between the CHCs and the communities, whereby the Makhulus would play a pivotal role as the first-line practitioners in the home environment. (18-22) This suggestion posed both a challenge and a problem, as mini-epidemiological projects had already shown that clients were reluctant to mention any other form of alternative care that they may have tried before visiting the CHCs. (18-22) Consequently the existence of prior knowledge of health care was ignored and stigmatised. (18-22) This observation is further confirmed by Gessler, Msuya and Nkunya (18) in their paper on traditional healers in Tanzania. They point out that some of the traditional healers complained about the attitudes of Western-trained medical staff towards their practice and knowledge, as they are blamed for a worsening of the client's condition.

Despite these challenges, the community health forums saw the recognition and use of community-based resources as the basis for effective PHC. (11,12) They further suggested that there might be a need to uncover this knowledge so that it can be made known. (3,19-22)

From these community health forum meetings, it was concluded that:

- a. there is a need to gain a better understanding of how many clients visit the CHCs and present with minor health ailments, including their reasons for seeing the CHCs as the appropriate place where these ailments should be managed (19); and
  - b. the IHK carried by the older women residing in Khayelitsha and Phillippi be explored.
- (3)

### **1.3 PRELIMINARY EXPLORATORY WORK**

This section briefly discusses the findings of Zonke's (3) preliminary exploratory studies of IHK from four focus group discussions (FGDs) conducted with 36 older people residing in Khayelitsha. The findings of this exploratory work are critically important to understanding the rationale for conducting this doctoral study in rural Eastern Cape and assisted in delineating the boundaries of the study.

#### **1.3.1 Brief description of Zonke's research methods**

In 2005 Zonke (3) conducted an exploratory, descriptive study to determine the IHK carried by older people in the management of minor health ailments in peri-urban area in Cape Town. Zonke (3) collected data from four focus groups (FGs) (nine participants in each), comprising senior citizens who resided in Khayelitsha and Phillipi. The ages of participants were between 60 and 70 years, with 66 years as the average. (9,10) Fifty-two percent (52%) of the group were females. Eighty percent (80%) were originally from the Eastern Cape and the majority of these mentioned that they had been living in Cape Town for approximately 20 years. An interview schedule was used so that the FGDs centred around four themes (3):

- a. What minor health illnesses do the older people manage at home?
- b. What home remedies do they use in the management of these minor health illnesses?
- c. When would an older person give up using home remedies and refer to an outside source?
- d. Who would they refer to for further management of the illness?

A qualitative analysis of the data helped to unlock an understanding of the IHK used by older people living in Khayelitsha and Phillipi. A brief description of results follows.

### **1.3.2 Brief description of Zonke's results**

Zonke's (3) results produced three main findings:

- a. The older women residing in Khayelitsha and Phillipi carried IHK.
- b. These older women had retained their IHK.
- c. Indigenous herbs/medicines were hardly available in Cape Town.

#### ***1.3.2.1 IHK carried by older women from Khayelitsha and Phillipi***

In community health forums the older women proposed that there are community- based resources such as IHK carried by the older Xhosa women that could assist in alleviating the overcrowding of CHCs by clients with minor health ailments. In Zonke's (3) exploratory study the older people mentioned a long and exhaustive list of ailments that they thought could be managed at home. They were unhappy about having their knowledge described as 'management strategies for common or minor health ailments', because they maintained that in years passed, there was no distinction between minor and major health ailments and that all health ailments could be managed and contained within the home situation.

#### ***1.3.2.2 Retention of IHK by the older women***

Questions arose about the older women's retention of and the validity of IHK, since the majority of them came to Cape Town about 20 years ago. The older women felt that their families did not give them the same status that they were accorded in their rural homes which would enable them to manage health problems at home. They were seldom consulted when somebody was ill. Instead, people went to the CHCs. The older people acknowledged that it is a long time since they were given free rein to practise their healing vocation in the home. Hence, they feared that they may be out of touch with it. (3)

#### ***1.3.2.3 Availability of indigenous herbs/medicines in Cape Town***

The older women shared how they had learnt their IHK from their grandmothers in the rural Eastern Cape and that this was where they had started practising their healing vocation. However, they complained that they experienced difficulties in Cape Town when trying to obtain the necessary indigenous herbs/medicine to use. Hence, in order to obtain a true depiction of the healing capabilities of older Xhosa women and the indigenous herbs/medicines that they use, it would be necessary to examine the IHK of the older women in the Eastern Cape – their place of origin. A further link between the older Xhosa women who were interviewed by Zonke (3) and people who overcrowd the CHCs with minor health ailments, lies in the fact that 80% of both groups originated from the Eastern Cape.

### **1.3.3 Impact of Zonke's study on the methodology of this doctoral study**

Zonke's (3) study impacted on this doctoral thesis in that it influenced the choice of participants and the study site, the boundaries of the study, adjustments made to the objectives and tools, and adjustments made to the depth and scope of the study.

#### **1.3.3.1 Participants and the study site**

South Africa consists of a multicultural social setting of 11 official languages situated across nine provinces. Within these different cultures and settings there are differences and variations as to how older people contain and manage health problems at home. The current doctoral study began with the identification of the problem of overcrowding at CHCs by clients in urban Khayelitsha, which has a population which is predominantly Xhosa. (3,19,20-24) In the preliminary studies, the older people who affirmed that health problems in general and minor health ailments in particular could be contained within the home situation had originally hailed from the rural Eastern Cape. (3,19) Therefore, the current doctoral candidate turned her attention to the IHK possessed by older Xhosa women who reside in the Eastern Cape.

#### **1.3.3.2 Boundaries of the study**

In the exploratory study conducted by Zonke (3), the FGDs occurred in urban area senior citizen club halls. The terrain in which the participants practised their healing vocation was the home. In this doctoral study, the researcher conducted the study amongst the older people in the Eastern Cape, in the natural environment in which they practised their healing, namely, the home (see terminology used for this study on p.xxiv). (3,19,28) The older Xhosa women from the community health forums in Khayelitsha and Phillipi proposed that the older female person holds the highest position in the hierarchy regarding the management of health problems in a traditional Xhosa home. (3) This suggestion needs to be further verified by this study.

#### **1.3.3.3 Adjustment to objectives and tools**

The older people disagreed with the notion that their healing vocation was only for minor health ailments. They said that when somebody is ill at home, especially at night, the approach would be to contain the illness through the alleviation of pain and suffering, as well as make the ill person feel supported and cared for, rather than differentiating whether the illness is minor or major. (3) In addition, there was the geographical problem of health services being far away. In the Eastern Cape, the majority of people still struggle to gain easy access to health services due to the long distances they have to travel. Therefore, the older Xhosa women would be the first to be consulted when containment of illness was

needed at home. This doctoral study therefore set out to explore all health problems that are managed by older Xhosa women at home.

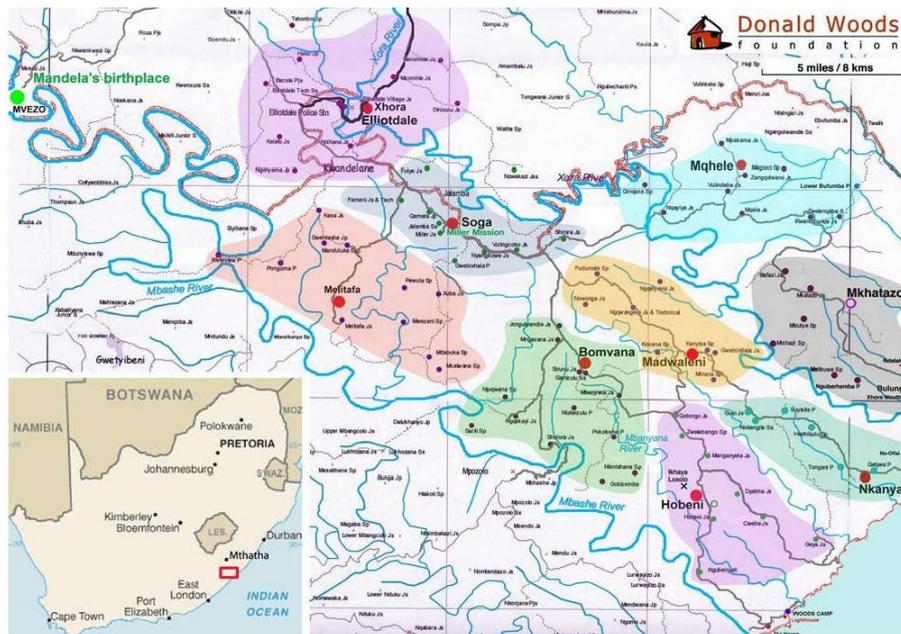
#### **1.3.3.4 Adjustment to the depth and scope of the study**

The complex concept of IHK which involves both health and culture (7,8), as well as survival skills and belief systems was explored in Zonke's (3) study using the single approach of FGDs. These FGDs may have yielded superficial results in terms of perceptions about the management of minor health ailments at home, with a tendency to lean in favour of the older people, without their notions being further verified. Taking this into account, this doctoral study added the following objectives to the original four explored by Zonke (3), namely:

- a. to explore the IHK of older women who are regarded as the elite bearers of this knowledge (3,4);
- b. to explore why the families of the older Xhosa women were consulted when someone in the family was ill (9,10); and
- c. to describe the type of care that was received from the elite group of older Xhosa women, in terms of the descriptions shared by the key informants who had experienced critical incidents. (1,2)

### **1.4 THE IDENTIFICATION OF THE RESEARCH SITE**

Considering the outcomes of Zonke's (3) exploratory study, the place that was identified as the research site for this doctoral study, was KwaBomvane in Xhora (Elliotdale) in the Eastern Cape Province (see Figure 1.1 below). The people who reside here are called Amabomvane, and are one of the most interesting tribes in South Africa. (30) They speak Nguni-Xhosa, a Bantu language spoken by more than 3.9 million South Africans. The breakdown of their tribal economy forced the traditional Bomvana towards the turmoil of rapid cultural change. This process of acculturation in South Africa, which affected thousands of Africans to mainly work as labourers in mines in South Africa was orchestrated mainly by the industrial powers. The impact of migrant labour on Bomvana life cannot be overestimated; their manpower in the vital period of life (18-50 years) was continuously withdrawn from their tribal society and mobilised for the labour market. (30) Below in Figure 1.1 is the map of part of Elliotdale, showing Madwaleni Hospital, the eight surrounding clinics, the villages, Mbhashe and Xhora river and part of the Indian Ocean.



**Figure 1.1: Map of part of Elliotdale, showing Madwaleni Hospital, the eight surrounding clinics, the villages, Mbashe and Xhora rivers and part of the Indian Ocean.**

#### 1.4.1 Key aspects of the Amabomvana culture that impact on this study

##### 1.4.1.1 Education

Education had effectively split the Amabomvana into two groups:

- the 'red' illiterate people (*amaqaba* = people who paint themselves with red ochre and are classified as traditionalists); and
- the 'school' people (*amaqhobhoka: abantu basesikolweni* = people who have left traditional life and are usually Christians and to some degree are Westernised. (30)

##### 1.4.1.2 Social position in the tribe

Status in the tribe depends on three factors: birth, sex and age. The man plays the dominant role in tribal life. However, a paternal grandmother may enjoy an authoritative position in her *kraal* and can give instructions as to the type of health care to use beyond the home. The tribal custom of *ukuhlonipha* refers to the respect people must show towards those of a specific age, sex and birth class. The culture of *ukuhlonipha* embraces:

- the respect of the young towards the aged;
- the avoidance by women of the cattle kraal and of the male side of the hut, causing women to make a wide detour in and around the hearth; and
- a linguistic way of talking whereby a woman is not allowed to utter the name of her husband nor the names of the male ascendants of her marital home.

### **1.4.1.3 Socio-economic life**

The Bomvana are pastoralists and agriculturists. Their economy is interwoven with social and religious life. The possession of land and cattle, for example, is necessary for full participation in the social and religious life of the tribe. The density of cattle in Amabomvana land is the highest in the whole of the 'old' Transkei. Today many Bomvana families live below the poverty line, and migratory practices have eroded the stability and backbone of the family unit.

### **1.4.1.4 Disease patterns and health conditions**

In the past three main health conditions in children were treated at hospitals: diarrhoea, pneumonia and malnutrition. More recently, TB and HIV are also being commonly treated, along with conditions which include vitamin deficiencies, anemia, measles, whooping cough, bilharzia and injuries from trauma and burns. With adults, a number of cardiovascular diseases and some forms of cancer that usually present at a late stage are found. Most children are born at home and it appears that there are more toddler deaths than infant deaths. It appears that the post-weaning stage is the most critical period in the lives of children. (30)

### **1.4.1.5 Rituals and ancestors**

The Bomvana feel themselves totally dependent upon their own ancestors in all the vital aspects of life: procreation, cattle and other property, as well as in the 'being' of the family as a whole. According to the Bomvana, *UThixo* (God) existed from the very beginning and emerged from the sea. *UThixo* was the first ancestor from whom the people originated. God was brought to bear by Amabomvana when they needed a way of filling in the gaps in their knowledge. This filling up of the gap with God also happens when a relative is ill and they lack both knowledge of the illness and the skill to help the relative concerned, so they use the hospital as a 'last resort'. It is perceived that this is due to the fact that the hospital itself was a mission hospital and the Bomvana related to the care at Madwaleni Hospital as being similar to praying.

The relationship with ancestral life in Bomvanaland is the ultimate concern to which all social aspects of life can be referred. It is not only a social phenomenon; it is a religion, but a religion of great social importance. Ancestral religion is not a compartmentalised concept to the Bomvana, 'It is life to the African thought'. (30) This is expressed in the welfare of the group and is of greatest concern to the indigenous health beliefs in the tribal system. (7,8)

## 1.5 MOTIVATION FOR THE STUDY

Fourteen years after the advent of democracy in South Africa and the implementation of PHC, a critical examination of the type of health care delivered in community-based health services, indicates that universal access to health care is far from being fully realised. (9-19) There is a general perception that the strategies developed to achieve this goal are narrow, and that they conflict with the needs of the communities that they are supposed to meet. (15-19,31)

The older people in Khayelitsha advocate that the management of minor health illnesses be dealt with in the *home situation*, thus leaving health professionals free to educate clients about health care and maintenance. The health care services are currently unable to fulfill this role as they are overburdened. Mlenzana (19) exposes the complex relationship between health professionals and their clientele. She further expanded on the multiple dimensions of health, including the way we lead our lives, and how this has a direct and indirect effect on our health. (19)

The community health forums that discussed the problem of overcrowding at CHCs in Khayelitsha recognised the complexity of health-seeking behaviours. They placed this behaviour within the context of an environment of migration, broken family units, and displaced traditions, including scarce community-based resources, such as IHK carried by the older people. This notion is supported by Buhrmann (32) who asserted that the concept of 'community involvement' implies that health care is not only the responsibility of external agencies and specially-trained health practitioners or the family physician, but that the whole community has to ensure that the health of every member is maintained at an optimum level. She argues that health in many preliterate societies depends on the survival of the group through the ability of all individuals to fulfill their roles, as well as through the knowledge of healing being passed on from generation to generation.

The challenge facing us today is to make the descendants and the owners of this huge repository of traditional health knowledge and medicine proud of it once more and confident enough to share it. Zonke (3), Gumede (33) and popular papers such as the Reader's Digest Association South Africa (34) explain how, in South Africa, health care changes have affected the status of indigenous knowledge, including the acknowledgment of the practice of home-based IHK. They emphasise that in the past, hospitals were unfamiliar places to the rural community. When people were ill, they managed their ailments at home with remedies provided by older persons. In the *home situation*, taking the ill person to a traditional healer was a form of referral that was resorted to only once home remedies had failed. (3,19)

Traditional knowledge is an important part of South Africa's cultural heritage. Before the development of synthetic chemicals, plants were one of the main sources of ingredients for medicines. They were also used as a source of food and as material for equipment. Wherever western world cultures colonised the world this knowledge became secret. South Africa, however, cannot afford to embrace an exclusively Eurocentric medical approach. (32) Eisenberg, Ronald and Kessler (35) maintain that other forms of medicines that are not within the biomedical paradigm are generally used as an adjunct to biomedicine, rather than as a replacement. In Eisenberg et al's (35) paper on unconventional medicine in the USA, a full third of the respondents who used unconventional therapy in 1990 used it for non-serious medical conditions, health promotion and disease prevention.

Mlenzana (19) and Zonke (3) both describe the level of mistrust that develops between health professionals and clients when clients have tried to contain the health situation 'on the quiet', using whatever home remedies are available in the home. This has resulted in their being chastised by health professionals for attempting home-based health management. This type of approach creates secrecy and mistrust, with health professionals perceiving the client as having used some form of 'voodoo *muthi*' prior to coming to the health centre. Because of this situation, the researcher conceptualised that this doctoral study would assist in the following ways:

- a. lift the veil of secrecy so that health professionals acknowledge the existence of IHK;
- b. identify dangerous practices;
- c. return status to the *home* and acknowledge it as being the nucleus where health issues can be *contained and maintained*;
- d. ultimately affirm the status of older women as being the *first-line health practitioners* who can form an important part of the PHC system in their respective communities.

Kleinman's (36) Cultural Systems Model suggests that in any complex society three overlapping arenas of health care can be identified: the popular, the folk, and the professional. It is however important to note that this model is frowned upon by experts in IHK, as it approaches culture as homogenous and unchanging, rather than as dynamic and heterogeneous. (7,8)

Although it would be easy to place the IHK carried by the older people within Kleinman's (36) popular arena, the participants in Zonke's (3) study identified an exhaustive list of ailments that could be managed at home. Therefore, the researcher postulates that in rural areas, older people, specifically women, have been filling a vital health care gap during South Africa's young democracy and during its attempts to organise the delivery of a comprehensive PHC service. During critical times of illness, homes and communities have

had to resort to whatever health care resources were available. This is especially apparent in rural communities where access to health care services is still a challenge. This notion is supported by Gessler et al (18) who maintain that in rural areas with their vast distances, alternative medicine may be the only available source of health care which is within reasonable reach. This study also attempts to show that where health services are available, responsibility for the management of minor health ailments has shifted to the health professionals. (18-22)

Scott and Wenger (37) examine how age and gender, frame or structure women's accounts of their health. They argue that women can become more powerful and autonomous in old age, taking on new roles and duties. Boneham and Sixsmith (38) maintain that the voices of older women are rarely heard in debates about health. Consequently, there is little research that explores the ways in which older women contribute to the health economy and social capital of their communities. In South Africa, with the high prevalence of HIV and AIDS, older people, and specifically women, have become the pillars of strength for AIDS's orphans. Achterberg and Clough (39,40) raise the issue of how women have always been carers and healers, but how women's legal right to practise their healing vocation has been gradually eroded by changing mores. This can in part be remedied by:

- a. recognising and valuing older women as key players in community health and as lay experts who are widely consulted by family and friends; and
- b. promoting a greater understanding that the knowledge carried by older women is passed on by word-of-mouth from generation to generation, and that if this knowledge is not researched and documented it will be lost to future generations.

Sinnot and Wittmann (41) maintain that there is not enough documentation of IHK although there is an increasing recognition of its importance in good health care delivery. In their study in Queensland, Australia, they implemented a three-tier plan to equip doctors with the necessary cultural awareness about health issues in order to facilitate positive experiences with indigenous patients. The rationale for Sinnot and Wittmann's (41) three-tier plan is that many positive, persuasive attitudes regarding indigenous health can be maintained and modelled by the more established doctors within the hospital structures. They conclude by proposing that an important step towards improving the health of indigenous people is the introduction of a culturally-appropriate health science education programme. (41) It is hoped that recommendations from this study will influence the curricula and education programmes of the Health Sciences, as well as research in the Faculties of Health Sciences at South African universities, thus eventually impacting on the clinical practice of these professions.

## 1.6 PURPOSE OF THE STUDY

The *primary* purpose of this study was to explore and describe the IHK carried by the older Xhosa women and used in the management of all health problems in their home situation.

The *secondary* purpose was to make recommendations to key stakeholders regarding the use of this IHK in the management of health problems in the home situation.

## 1.7 OBJECTIVES OF THE STUDY

There were primary and secondary objectives of this study.

### 1.7.1 Primary objectives

The primary objectives of the study were to explore, examine and describe the following IHK carried by the older Xhosa women from the Eastern Cape:

- their definition of health and illness;
- the health problems that they manage at home;
- the steps that they take to decide/diagnose what specific health problem the person has;
- the steps and management strategies that they use at home to deal with these health problems;
- the home remedies that they use to manage these health problems;
- whether different types of health problems (such as the critical health-related incidents) influence their decision-making;
- the rationale that would lead to their relinquishing health management strategies at home and referring the person to an outside source;
- the referral sources that they would use to further manage the illness and the rationale for that choice; and
- their opinions regarding how their knowledge could be integrated into the present health care dispensation, including the contribution it could make.

### 1.7.2 Secondary objectives

The secondary objectives were to:

- design and suggest a model for the integration of the IHK carried by older Xhosa women in the present PHC system; and
- make recommendations to key stakeholders regarding the future of this knowledge, including training options.

## 1.8 CONCLUDING STATEMENT

Preliminary exploratory studies demonstrated that CHCs in the peri-urban area of Khayelitsha, Cape Town, were overcrowded with a large number of clients being perceived as presenting with minor health ailments. It was postulated that this might be leading to a situation in which clients with more serious health problems are not being given the attention they require. These preliminary studies explored the IHK carried by the older Xhosa women in Khayelitsha, and raised questions about the validity of this knowledge and of the need to explore it in the place of the origin of the older Xhosa women – the rural Eastern Cape Province.

The complexity of the affirmation and integration of IHK carried by older Xhosa women into the current (biomedical Western) PHC system was recognised and a cautionary note taken about not using a unilateral approach to approaching the problem. The participatory and inclusive approach adopted by the community health forums and their management of the discussion, as well as preliminary exploratory work undertaken, contributed to three areas of this study, namely:

- a. the identification of the study area;
- b. the identification of the study sample; and
- c. the development of the methodology.

This preliminary work also contributed to the delineation of the research question and guided this study to its purpose and objectives as outlined below in Figure 1.2.

## **OVERCROWDED COMMUNITY HEALTH CENTRES (CHC) IN KHAYELITSHA:**

**CHC 1**

**CHC 2**

**CHC 3**

**CHC 4**

CHCs characterised by:

- daily overcrowding;
- majority of clients perceived to be presenting with minor health ailments;
- overburdened health professionals;
- minimal health education and advocacy regarding health maintenance.
- Preliminary mini-epidemiological studies regarding overcrowding of CHCs.

## **KHAYELITSHA AND PHILLIPI COMMUNITY HEALTH FORUMS INVOLVING:**

- CHC managers, doctors, clinical nurse professionals, etc.;
- community members and older people;
- students from Health Sciences Faculties at three universities in the Western Cape and their clinical facilitators

Community Health Forums responsible for:

- linking the CHCs to community and vice versa;
- dealing with problems such as overcrowding of CHCs.

## **PRELIMINARY IN-DEPTH INVESTIGATION REGARDING OVERCROWDING OF CHCs:**

- health seeking behaviour of clients in two Khayelitsha CHCs;
- IHK carried by older Xhosa women in Khayelitsha.

## **RESULTS FROM EXPLORATORY STUDIES:**

- acknowledgement of complexity of health seeking behaviour – need for further exploration of this area;
- acknowledgement of existence of community based resources such as IHK carried by the older Xhosa women;
- need to further explore IHK carried by older Xhosa women in their place of origin the Eastern Cape Province – hence this study.

**Identification of research site in the Eastern Cape Province.**

**Figure 1.2: The influence of the contextual issues on selection of the study site**

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

This literature review provides a detailed understanding of health definitions and health belief models. A rationale is given as to why the home is regarded as the place to manage and contain health problems, especially by way of indigenous health approaches. Health problems that are managed using what is classified as alternative medicines are specified including what researchers classify as minor health problems. What can be perceived as 'dangerous IHK approaches' are also discussed. The review also includes an analysis and expands on different concepts of IHK throughout the world, and recommends that further research is undertaken in this area. An overview of the South African public health care delivery system is presented. An argument is made for the need to integrate IHK into the South African health care system and into curricula of the South African Health Sciences Faculties.

### **2.2 INTRODUCTION TO HEALTH DEFINITIONS AND HEALTH BELIEF MODELS**

This section covers health definitions from the biomedical and the African perspectives. The biomedical perspective of different health belief models is provided by Gilbert et al (42) and Kleinman (36), while an African perspective is drawn from Maelena (43) and Lindell (44) . The section includes a description of the home as the place where health can be maintained and minor illnesses contained, with the older women in the home playing a pivotal role. A classification of what constitutes minor illnesses is presented, and illnesses that can be managed by alternative approaches are outlined. Finally, some insight into what could be classified as dangerous health management strategies is discussed.

#### **2.2.1 Health definitions**

The main focus of this section is definitions of health according to WHO and Indigenous Peoples. (7, 43-45) In 1948, the World Health Organisation (WHO) defined health as, "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". (45) According to Bok (45), this definition has generated much controversy ever since it was coined. It has been called masterful and dysfunctional, profound and yet meaningless. Its meaning has been defended as being indispensable in its present formulation, but also as needing revision. At times, it was held as having opened the door to the medicalisation of most of human existence, and at other times, to the abuse of state power in the name of health promotion. (45)

Fifty-one years later in 1999, the WHO arranged an international consultation in Geneva on the health of indigenous peoples. In 2002, arising from that consultation, a new definition of health that links culture, the wider, natural environment, and human rights was offered:

Indigenous people's concept of health and survival is both a collective and individual inter-generational continuum, encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, the present and the future co-exist simultaneously. (7:1138)

Bodeker (7) and Durie (46) argue that there is a need for health professionals to bear this definition in mind when dealing with indigenous people. Bok (45) calls for a revision of the WHO health definition of 1948. If over 60% of non-industrialised countries depend on IHC for their basic health care needs (46), in some African countries this figure is estimated to be as high as 90% (46), then it stands to reason that a universal health definition should include inputs from such population groups as well.

It is believed that traditional health systems thought and practice, diagnostic, clinical and herbal medication reactions also include empirical frameworks for understanding health. (46) According to indigenous approaches, illnesses occur when there are disturbances between the mind and body, as well as between different dimensions of individual body functions; between the individual and community; between the community and the environment; and between the individual and the universe. (46-48)

By breaking the interconnectedness of life, a fundamental source of disease erupts and can progress to different stages of illness, and due to the fact that disease has found fertile ground (the broken interconnectedness) it can spread to epidemic levels. (49) IHC treatments not only address the locus of the disease but also seek to restore a state of systematic balance between the individual and his or her inner and outer environment. The state of awareness marking the spiritual, intellectual and emotional well-being of a person is considered to be the basis of all material existence, and it is this state of awareness alone that appears to ground and anchor an individual. (46,47) There is a need to appreciate that the biological environment and spiritual conditions are contributors of illness.

Knowledge about the management of the natural environment serves as natural balance to people of that area and is also seen as important for contributing towards their well-being. The traditions of indigenous knowledge are systematic as seen in the way indigenous peoples view nature and classify and select medicine. For example, in Northern Brazil in the

period when the indigenous people were faced with the malaria epidemic, they developed an empirical approach to identifying those plants with anti-malaria effects. One major criterion was bitterness or antipyretic properties. (48)

For indigenous people, the spiritual dimension is always intrinsic to every material form, and matter cannot exist without spirit. There is a belief amongst many indigenous peoples that the properties of plants can be enhanced through understanding their spiritual connections. According to IHK, the subtler spiritual properties of plants are as real, and certainly more powerful, than the direct healing properties. (48) Some plants are representative of a woman who is good, virtuous and faithful, for example, the Tulasi plant in India. It also has medicinal components such as antipyretic, diaphoretic and expectorant properties. Biological activity tests have shown that the Tulasi enhances immune functioning by increasing antibody activity. (47,48) Thus, many indigenous plants like the Tulasi have strong survival elements and represent enduring cultural, spiritual, religious and traditional practices in their place of origin.

Many of the traditional practices of conserving plants are being eroded by commercial enterprises. Pharmacological industries use 'local people' as their raw material collectors. The consequences are that indigenous people lose their natural habitat as well as hundreds of plant species which eventually become extinct. The commercial usage of these plants is unlikely to promote traditional medicines which use only a fraction of their medicinal components. The loss of biodiversity not only threatens the ecology, but also the livelihoods of traditional communities who try their utmost to conserve traditional medicines. They interpret the commodification of their resources as exploitation since they see it as commercialisation without respect. (46-48)

Increasingly as indigenous people conformed to modern civilisation, their IHK was suppressed, for example by religious groups and by colonisation. (48) Critics see these developments as being underpinned by ideologies which aim to gain power and control of certain areas and their natural resources, at the expense of the health and preservation of the indigenous peoples. (48)

### **2.2.2 Health belief models**

Health-seeking behaviour can be seen as a process in which the beliefs and actions of the ill person, or the people in his/her immediate social environment, lead to seeking out treatment and to subsequently evaluating the outcomes of such treatment. This process does not simply involve diagnosing, labeling and treating the illness, but goes through stages in which the sequence continuously moves from explanation, to therapy, and on to evaluation. If

healing fails, the process is repeated so that new explanations are developed, and are then followed by alternative forms of therapy, which are then re-evaluated. (36)

### **2.2.2.1 Gilbert, Selikow and Walker's Cultural Model**

Gilbert et al (42) define health behaviour as an activity undertaken by persons who believe they are healthy, and aim to prevent or detect diseases during this asymptomatic stage. They suggest that illness behaviour is a culturally learnt response, suggesting that the experience of illness is defined according to the norms and values which are prevalent in a specific society or a community. (42) This approach emphasises that when symptoms are perceived as abnormal, people need to take the initiative to do something about them and to seek help. People who become ill typically access a hierarchy of resources, ranging from self-medication to consultation with others. Self-treatment is based on lay beliefs about the structure and functioning of the body, and about the origin and nature of ill-health. It includes a variety of substances such as patent medicines, traditional folk remedies, or 'old wives' tales, as well as changes in diet or behaviour. (42)

Once symptoms of illness have been recognised as serious, the activity that follows will be determined by the way things are usually done or the dominant mode of operation in a particular culture. In most communities, the first step in seeking help involves consultation with family members, friends and neighbours. Following that, the person might decide to seek help from traditional healers, consult Western/modern health professionals, approach alternative sources, or use a combination of these options. This process is similar to Kleinman's (36) popular and folk arenas, mentioned earlier (and below).

All communities and cultures have their own embedded concepts of health. Thus, what is experienced as health represents a complex, intimate and cultural understanding in a particular social context, rather than a fixed set of physiological and biochemical facts. Even in a culture in which scientific medicine is dominant in people's minds and outlooks, some individuals will still seek health or healing through different modalities of treatment, in certain cases based on what appears to be quite bizarre beliefs. (36,42)

### **2.2.2.2 Kleinman's Cultural Systems Model**

Kleinman (36) explained illness as cultural idiom, and saw a relationship between beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices, and evaluations of therapeutic outcomes. Thus for Kleinman (36) the health care system is a model that includes health, illness and the health care-related aspects of societies as articulated in cultural systems of those societies.

Each arena in the three overlapping arenas (the popular, the folk and the professional arenas) of Kleinman (36) has its own ways of explaining and treating ill health, defining who the healer is and who the patient is and who the patient is, and specifying how healer and patient should interact in their therapeutic encounter. Most health care systems contain all three health arenas within which illness is experienced and responded to.

*(a) The popular arena*

The popular arena is known as the lay, non-professional, non-specialist domain of society, where ill health is first recognised and defined, and health care activities are initiated. It includes all the therapeutic options that people utilise, without any consultation or payment of folk healers or medical professionals. The popular arena is seen as the real site of PHC because the family is the main and primary health resource and most ill health is identified and then treated within the home or family. Most health care in this arena takes place amongst people already linked to one another by ties of kinship, friendship or neighbourhood, or even membership of work or religious organisations. This means that both the patient and the healer share similar assumptions about health and illness, and misunderstandings between the two are comparatively rare. (36) An example of the popular arena, would be the IHK carried by older Xhosa women for the care of minor health ailments in their home situation. (3)

*(b) The folk arena*

In the folk arena, certain individuals specialise in forms of healing that are either sacred or secular, or a mixture of the two. These healers are not part of the official or public medical system, and they occupy an intermediate position between the popular and professional arenas. Most folk healers share the basic cultural values and world view of the communities in which they live, including beliefs about the origin, significance and treatment of ill health. When they heal people who are ill they frequently involve the family in diagnosis and treatment. The healer is usually surrounded by helpers, who take part in the ceremony of healing, give explanations to the patient and family, and who answer any queries. This is similar to the way Berg (49) explains the role of traditional healers. From a modern perspective, this type of healer with helpers, together with the patient's family, provides an effective PHC team.

In Apartheid South Africa, especially in rural areas, people were largely left to the ministrations of traditional healers, the good offices of missionaries, and the patent medicines of traders. According to the WHO, professional health services were largely inaccessible to the people living in these far-flung areas. (50) In certain areas in Africa, this situation still prevails today. (51-57)

(c) *The professional arena*

The professional arena comprises the organised, legally-sanctioned healing professions, such as modern Western scientific or allopathic medicine. It includes not only physicians of various types and medical specialties, but also the recognised allied professions such as nurses, midwives or physiotherapists. Healers in this arena have the power to question or examine their patients, prescribe powerful and sometimes dangerous treatments or medication, and deprive certain people of their freedom by confining them to hospitals if they are diagnosed as psychotic or infectious. When consulting a professional, the ill person is removed from family, friends and community, at this time of great personal crisis. Patients undergo a standardised ritual of 'depersonalisation', and become a numbered 'case' in a ward full of strangers. The relationship of the health professionals with their patients is often characterised by distance, formality, brief conversations, and often the use of professional jargon. (30)

Some of the attributes of the professional arena are similar to those found by Gessler, Msunya and Nkunya. (18) They described the health care delivery by health care professionals in CHCs as being characterised by brief encounters with doctors or hospital staff (often less than five minutes), with the patient feeling confused and alone in a foreign environment. Gessler et al's (18) study was based on experiences at CHCs, while the professional arena, which is a sub-model of Kleinman's model (36), is based on experiences in hospitals. There are similarities in both models, namely:

- a. consultation happens away from the home, where illnesses are first declared;
- b. consultation happens away from family members who usually give support in indigenous consultations; and
- c. time taken with the person in both areas, is brief and rarely includes the home or community.

Atkinson et al's (58) study noted the importance of interpersonal aspects of the patient-professional relationship, such as amount and clarity of information regarding the condition of the patient, bedside/chairside manner during consultation, similarity of socio-demographic backgrounds, and the extent to which the patient can express opinions. A better patient-professional relationship was more positively associated with satisfaction about health/treatment outcomes. In other words, Atkinson et al (58) found that user satisfaction is an important outcome in its own right, since it predicts patient compliance with treatment, re-attendance at the clinic, and even improvement in health status.

User satisfaction can be assessed in the communication patterns in the patient-professional consultation, relying on, *inter alia*, factors such as information transfer, user involvement in

decision-making, and reassurance about the patient's condition. These assessment indicators are an important part of the indicators used to compare and plan different ways of organising or providing health care.

According to Myerscough and Ford (51), most people who are unwell look to the doctor for help, advice or reassurance, and in so doing assume a dependent role as a 'ill person'. This submission to their medical attendant derives from feelings of uncertainty and fear that come with illness. This carries the danger of promoting a paternalistic attitude, which the doctor must guard against, since it may lead to overlooking the patient's needs and concerns. Others find that being ill is the only sure way of gaining the attention and concern of those around them. These attention seekers experience recurrent ill health year after year.

### **2.2.2.3 African indigenous health belief models**

As previously mentioned, the African representation of illness, treatment and prevention is largely dependent on the culture that one embraces. Maelene (43:15) remarks:

Traditional Africans do not believe in chance, bad luck or fate. They believe that every illness has an intention and a specific cause, and in order to combat the illness, the cause must be found and counteracted. In the quest to understand illness, the questions "Why?" and "Who?" are uppermost in the minds of traditional Africans.

It could be interpreted as a positive and exciting way of thinking if interpreted within the asset model of health promotion and the willingness of health educators to work with traditional African people in developing the links between the biomedical approach and the traditional African approach. According to African tradition, proximate (immediate) as well as distal or ultimate causes of ill-health require treatment, if a disease is to be cured. (43,44) Diseases manifest themselves not only in physical symptoms, such as fever or pain, but also in mystical disturbances of the blood, commonly described in terms of impurities. (44) To treat proximate causes and physical symptoms, people may consult medical personnel and/or traditional healers for appropriate remedies. However, treatment for ultimate causes must also be sought. These mystical conditions belong to the spiritual domain, which only traditional healers or diviners are capable of healing by way of their insights and therapies. (44)

Prevention of illness happens at two levels: societal and individual. At the societal level, the belief that violations of social, religious or sexual codes of conduct will bring about disease - either through the actions of other people or through ancestral intervention - comprises a powerful mechanism for ensuring social cohesion and stability. (49-51) On the other hand, at

an individual level, malevolence can target an individual person, for example, through infertility, high rates of infant mortality, or adult sterility. If mystical forces dominate human experience, then believing that these are rational forces gives a sense of order to unfortunate events. The general breakdown in traditional family life that is accompanied by the prolonged absence of the head of the household can bring illness to that household. Thus to avoid being possessed by illness, one needs to observe stricter social and moral codes. (43,44)

These representations of illness have been carried into the current, modern world. As an example, around 1910 the Zulu people of South Africa believed in *indiki* and *ifufunyane* which they associated with the disruption that migrant labour (and high-risk occupations such as construction work and underground mining) brought to families. When migrant labourers were killed at work their remains were buried close to the working area and not at home. Consequently, there was a belief that their spirits were too far away to benefit from sacrifice and as ancestors they were unable to monitor the daily functioning of their families. Thus it was believed that these spirits would possess a live Zulu man in the mines in a last-resort attempt to return home with him and be able to assume an ancestral role within the family – hence the possession of these Zulu men with *indiki* or *ifufunyane*. (44)

Despite the perception by missionaries, doctors and educators that they were entering a zone of pure ignorance regarding health matters, Lidell (44) maintains that illness theories in the sub-Saharan African cultures had readily accommodated some of the biomedical concepts of the twentieth century. However, the fundamental principles on which they are founded lay much further back in history. Thus, Lidell (44) presents three types of categorisation for illness in sub-Saharan African cultures:

1. Type 1 illnesses have no discernible moral or social cause. These tend to be *minor ailments* such as rashes and colds. These are the only illnesses that occur by chance and for which causes are not sought.
2. Type 2 illnesses are modern diseases that can be contracted by people anywhere in the world, and that were first introduced into Africa by European settlers.
3. Type 3 diseases are those that only African people contract and to which all Africans - regardless of tribal or geographical origin - are vulnerable.

As previously explained, the attempt to find out the causes of illness would only relate to Type 2 and 3 illnesses, since these can usually be related to discernible proximate and ultimate causes. The first approach would be to look at the condition within the proximate dimension, for example, infections and contagion caused by pollutants. This understanding predates medical models. Next would be to search for an ultimate cause, looking at why a disease was contracted by a particular person. Liddell (44) provides the example of a mother

who can understand that the cause of her child's diarrhoea might be due to flies that have settled on the child's food (proximate cause); but she will also want to establish who sent the flies (ultimate cause). Liddell (44) highlights three types of causes that are used to explain ultimate causes:

1. *Contact with pollutants*: Pollutants often originate from other people's bodies and include semen, menstrual discharge, vaginal secretions and blood, and might lead to infections such as HIV and AIDs and might ultimately lead to death. These inherently polluting discharges are equally dangerous to both healthy and ill people and thus people need to fortify themselves from contamination by maintaining strict moral codes and observing protecting rituals.
2. *Witchcraft and sorcery*: Illness can be inflicted by people who have been offended by the victim's behaviour. Failure to honour filial obligations, violence, or other forms of unco-operative behavior, risk creating a level of offence that can lead kin or neighbours to seek redress through witchcraft.
3. *Ancestral vengeance or punishment*: The survival of ancestors in the spirit world depends on their being accorded regular attention from living offspring. This attention is manifested in rituals, sacrifices, avoidance of taboo, and high standards of social behaviour. Where these requirements are not met, illnesses can be sent from the ancestors as a warning or punishment.

Together with the emergence of new diseases, new epistemologies have usually been incorporated into the culture if they resonated well with the old. So, for example, the Christian belief that epidemics are sent by God as a punishment for sins resonates well with indigenous beliefs about the ultimate causes of illness, except that ancestors and witches are now joined by a Christian God. (44) In this way, indigenous beliefs about the ultimate causes of illness have had ample opportunity to remain intact.

It is not unusual to find that people consult both traditional healers and medical doctors about both proximate and ultimate causes of disease. In South Africa, there are more than 300 000 traditional healers, 15 times the number of medical doctors. (3) In Nigeria, there is evidence that people depend more on traditional healers for treating HIV and AIDS than they do for any other disease. The rationale is that sexual matters are the special remit of traditional healers. (43,44) In addition, traditional African people believe that traditional healers would be able to answer such questions as: how is it possible that two men exposed to the same woman do not both become infected and affected? According to Maelene (43), to blame external factors such as witches and sorcerers for HIV and AIDS has two functions. Firstly, it

prevents feelings of guilt and alleviates anxiety; and secondly, it provides people with answers that science cannot give.

The view of traditional Africans has serious implications for health education and the prevention of illnesses, especially those related to sexuality such as HIV and AIDS. (43,44) The traditional view of sexuality in African culture is that women should get married and have children, and amongst those children there should be a son; failing which the man will find another wife to try his luck for the birth of a boy. To the African family, a boy means an extension of the family and a way of keeping the family with the living and the dead. (43) This attempt to have a son might continue with the extension of wives, until a male heir for the inheritance is born.

In the traditional African family, having children is extremely important if the African people are to prosper (in terms of land and ancestors) as a whole, as a man's wealth is linked to the growth of his tribe. Maelene (43) argues that once Western AIDS counsellors understand the issue of immortality in traditional African terms, they might start to understand why polygamy is practised in many African cultures. They might even start to understand why convincing Africans to use a condom is so difficult, and why African women insist on having children, even when they are HIV positive.

While Western health educators might frown upon the prevalence of polygamy in African societies, polygamy often serves to reduce infidelity, prostitution, STDs and HIV. (43) In some African cultures there are certain times when sexual intercourse between a husband and wife is prevented, for example, while the woman is pregnant or during lactation up until weaning (usually when the child is between three to four years of age). However, the African man believes that sexual engagement and the release of semen is a healthy phenomenon in which a man should frequently engage. African men are very concerned that their newborn infant should thrive and so he does not expect to have sexual interactions with the mother, as this is seen to compromise the development of the child, for example, leading to stunted growth. In addition, there is also a chance that the mother would fall pregnant again before the child is fully grown, thus further jeopardising the growth of the child. So, instead of consorting with outside partners, the man remains within the circle of his wives. (43)

Liddell (44) explains that when a man is receiving traditional medication for an STD such as HIV and AIDS, there is a belief that this medication is cleaning his blood and that the impurities will be released via bodily excretions, including semen. Thus, during this period the man will not want to sleep with his wife as his semen will make her ill and could cause a further spread of the disease. He thus chooses to sleep with somebody he cares for less.

Both Liddell (44) and Maelene (43) caution Western-trained health educators not to label the reluctance to wear condoms as promiscuity, permissiveness, or a lack of moral and religious values. These labels simply demonstrate a lack of understanding of the African philosophy underlying sexuality, as well as a disrespect of African values. The challenge is not to blame but to develop an understanding of hidden cultural beliefs. Some of these beliefs about condoms include:

- Condoms block the gift of God. Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction represent an exchange of the gift of self, which they see as very important in a relationship.
- Condoms undermine the central tenet of traditional African thought, namely that life-enhancing forces are expressed through fertility. Abstinence too is a challenging concept as it denies the opportunity for sexual release which is thought to be essential for health, at the same time it stifles the expression of fertility.
- Condom use is interpreted as wasting and showing disrespect for a treasured resource, namely, sperm.
- Condoms are believed to prevent the ripening of the foetus. The South African Zulus, for example believe that semen is needed to form or ripen the growing foetus in the womb, and that condoms interfere with the process of natural foetal development. (43,44)

Maelene (43) calls upon all health care practitioners and educators, especially those working in rural areas, to take these health beliefs into consideration in their health education programmes. This notion is supported by Zonke (3), Gessler (18), Mlenzana (19), and Burhman (32), in their studies of CHCs in peri-urban environments in South Africa, where they found that clients alternate between using Western and traditional medicine. (46-48) In fact, medical doctors in Southern Africa acknowledge that traditional healers carry most of the burden for treating diseases like HIV and AIDs. (44)

It is interesting to note that the HIV/AIDS epidemic has exposed the huge gap between traditional medicine and biomedicine in terms of understanding and responding to illness. Many of the biomedical prevention messages about HIV/AIDS are in direct contradiction with African beliefs about fertility. This threatens the seamless and functional relationship between cause, treatment and prevention valued by traditional African people. However, there is a need for the two schools of thought to come closer before another epidemic emerges. Medical doctors tend to practise from a distance and are usually overburdened with too many patients; while traditional healers are more likely to pay the patient a home visit, especially when the illness is serious, such as HIV/AIDS. (44) In addition, in the eyes of

the community, traditional healers have more authority than nurses, who are usually only responsible for palliative care. Green, in Liddell (44) sees traditional healers as:

... priests, religious ritual specialists, family and community therapists, moral and social philosophers, teachers, visionaries, empirical scientists and perhaps political leaders in addition to being healers in the more restricted Western sense. (44:36)

This multiplicity of roles played by traditional healers makes it difficult to ascertain what the continuing reliance on them signifies and we cannot simply assume that the reasons people consult them have remained the same over time. Green's (44) account suggests that traditional healers offer a more comprehensive approach to disease. This concurs with Liddell's (44) view that traditional healers show greater insight into people's beliefs and thus offer greater flexibility than western-based healers. For example, many traditional healers tell their clients that HIV is an infection brought about by evil spirits and that the use of a condom can trick these spirits. Others have even put up dildos as a permanent feature in their places of worship.

Nsameneng (in Liddell) (44) argues that African indigenous beliefs have not been extinguished by colonial imposition or Western adaptations. The on-going prevalence of traditional healers in modern society is itself evidence in support of the persistence of indigenous beliefs about illness. However, social scientists are reluctant to explore indigenous knowledge as they fear that they would be seen to be examining work that is outdated and belongs to another era. (44)

Traditional healers are not only diviners and herbalists, but they also include older people who regularly use indigenous methods and strategies in health management. In the short term, ignoring IHK beliefs about illness, which African societies have long construed as essential for their survival and well-being, seems counterproductive to the management of illnesses in Southern Africa (43,44) and to the development of culturally-grounded health prevention programmes. (59,60)

It is interesting to note that in South Africa in 2012, a national professional council for traditional healers is in the process of obtaining recognition from the government for their treatment methods. (28,33)

### **2.2.3 African approaches to health care in the home setting**

In any African society, the home is the heart of everything. It is where things start and it is where things end. (28,33) According to the Reader's Digest Association of South Africa (34), this concept of home dates as far back as the Iron Age, when African people used all available resources to survive. In those times life was simpler and natural plant resources

were the main source of medicinal, cultural, religious and other needs. (30) Older people, specifically older women, played the important role of maintaining stable health within the home setting.

People in rural settings relied on cattle farming and natural vegetation for their survival and for their livelihoods. (34) The home was where creating and inventing happened, where new technologies were developed, and where natural resources were used to treat health problems.

Mtyaphi in Zonke (3) argues that older women were accorded recognition and respect in their families, because of their prior knowledge and experience, and their wisdom was utilised effectively in all instances in the home including for the management of health issues. They reared the grandchildren and passed on the beliefs and culture of the community, thus leaving the second generation free to become the productive generation. (30)

In the Xhosa tradition, a girl grandchild acquires knowledge predominantly from the grandmother. When she marries, she moves to her in-laws and is integrated into their household as an apprentice to her mother-in-law. (30) In this way she absorbs the culture of the new household, including their knowledge, such as the use of herbs. Although she still holds the knowledge from her grandmother that she came with, she practises it silently, only bringing it into the open to support her mother-in-law during critical incidents. When her children are born, they fall under the supervision of her mother-in-law and she becomes the observer and learner, and validates the knowledge she brought from her own grandmother. (30)

Once a married woman assumes the role of grandmother, she would feel more confident about supporting the family, as her knowledge, experience and wisdom, has been validated again and again, as being important in the day-by-day events of the family setting. (30,32,60) Older women monitor the health of family members. (3, 30) According to Bhat and Jacobs (61), if a family member falls ill, the older woman watches the person's behaviour, examines the patient, decides which herbs could be used for treatment, and later prepares a treatment mixture using available plants. Grandmothers (*Makhulu*) have a sense of responsibility when fulfilling their role of maintaining stable health in the family. They have the patience to help the ill person and a passion for what they are doing. (3)

Murdock (62) maintains that the older woman is like a guide to the mysterious realms of the feminine. She is remembered by the younger women as a safe haven, a source of nourishment, a caretaker during illness. She embodied the qualities of feminine insight, wisdom, strength and nurturance, which may be missing in daily human life when she is not

part of this system. The older woman has practised and sharpened her qualities and skills as a caretaker and nurturer earlier on in her development. As women bring life into the world, they are expected to develop skills on how to nurture and care for this life through to adulthood. (62) From conception up until birth and through the growing years, society expects women to have the wisdom of caring. (39)

Zonke (3), Igreja (60) and Bhat and Jacobs (61) maintain that the home is where healing first occurs. In the patriarchal African society, women are first expected to give birth to healthy sons and then maybe also some daughters (60). Banda (63) asserts that if a child is born disabled, the blame is cast on the mother, since she must have done something for this to happen. The very partner who was party to the making of this child is the first one to distance himself from the situation. Stories of disabled children who have been killed at childbirth litter the history of the birth of children, and are grim reminders for the expectant mother of the high expectations that she should give birth to a healthy child. Even today, in the more enlightened times in which we live, in countries such as Ghana, women resort to killing and throwing their disabled infants away, to exempt themselves from blame and shame. (64) Knowing and understanding the lofty goals of caring and nurturing, women have had to learn how to achieve these goals with the support of other, and often older, women. (38)

Through experiential instruction from their own grandmothers and other older women around them, women have developed, and continue to develop, various strategies to strengthen the home, including its health care needs. Through trial and error they have used herbal remedies to heal their families and to assist other families in need. (39)

This is the situation that the first colonisers found amongst the Xhosa people. (28,60) They came to the colonised states, carrying their religion and Bible, and with their European and western world notions of education and scientific healing. (28,60) It was during this period that not only were the indigenous healing abilities and healing spaces taken away from the home, but that the home's multiple roles as the first creator and nurturer of knowledge, culture, beliefs and productivity, were all siphoned into institutions designed to build an industrial empire in which women had little say. (39)

Zonke describes the home as the complex terrain in which closely related family members live and interact. (3) It is an organisational structure, which has its own hierarchy, relationships, organisational norms and life obvious and also sometimes hidden or unspoken. (28) The home is also where personal and private matters, such as illnesses, are declared and contained, and the social determinants of health are practised and played out. (3,19)

Fry (54) states that the original setting for most PHC is probably the patient's own home, and that this tradition has persisted in some countries, although it is becoming less common. As already stated, Fry's observation is borne out in the traditional Xhosa home, where the female older person holds the highest position in the hierarchy regarding the management of health problems. The advantages of this to the patient include concerns regarding health status, the avoidance of discomfort and the cost of travelling to a PHC unit, as well as a reduction in the real or imagined risks of catching infectious diseases from other patients. The disadvantage for the patient is that he or she may be examined and investigated less thoroughly in the home situation, or that more serious conditions may be missed. Fry appears to be suggesting that only minor health ailments should be managed at home, which is a view that is in contradiction to that of the group of elderly persons residing in Khayelitsha and Philippi, who believe that, when health facilities are only available at a distance, and one has to cope with an ill individual at home, no differentiation occurs between whether it is a minor or major illness, as the priority aim is to relieve pain and suffering. (3)

#### **2.2.4 Health problems commonly managed by alternative/unconventional methods**

Eisenberg et al (35) note that, in America, unconventional (i.e. non-biomedical) medicines and therapies were used significantly more often amongst people with a college education than amongst those with no college education (44%, as compared to 27%), and was significantly more common amongst people with an annual income of above \$35 000 (39%) than among those with a lower income (31%). The vast majority (83%) also sought treatment for the same condition from a medical doctor; however, 72% of the respondents who used unconventional therapy did not inform their medical doctor that they did so. Unconventional medicines were also more commonly used by people living in the West (44%). In 1990, Americans made 425 million visits to unconventional therapists as compared to 388 million visits to primary care physicians. Expenditure related to unconventional therapy in 1999 amounted to approximately \$13.7 billion of which three quarters were paid out of pocket (\$10.3 billion). The conclusion that Eisenberg et al (35) come to is that medical doctors should ask patients' use of unconventional therapy whenever they obtain medical history.

While health professionals in CHCs are chastising patients for using methods of health care other than conventional methods, it would appear that in the USA - the very country which is used as the yardstick for best-practice - patients, especially those with a college education, are opting for unconventional treatments. Mishra, Hess and Luce (8) and Mugisha Kouyate, Gbangou and Sauerborn (65) noted that there are many reasons which influence patients to go outside conventional health facilities. Some of these are related to poverty and not being

able to pay the costs of conventional care; while others are confident that they can manage their illness at home.

Other than chastising patients, would it not be better to try and understand why they opt to utilise unconventional therapy and home medications? Table 1 presents the medical conditions that most commonly prompt patients in USA, the Samoans and South Africa to seek unconventional health care.

**Table 2.1: Medical conditions managed using unconventional health care**

<b>Medical condition1 (United States of America)</b>	<b>Percentage reporting</b>	<b>Medical condition2 (Samoans)</b>	<b>Percentage reporting</b>	<b>Medical condition3 (South Africa)</b>	<b>Unconventional versus physiotherapy visits</b>
Back problems	20	Musculo-skeletal (acute & chronic)	30	Chest conditions	124/150
Allergies	16	Gastrointestinal	18.7	Poisoning	225/0
Arthritis	16	Neurological	16.6	Venereal disease	167/24
Insomnia	14	Dermatological	10.6	Fracture	127/202
Sprains or strains	13	Pallor, drooling and swelling	8.2	Hypertension	175/3
Headache	13	Obstetric (pregnancy massage)	3.1	Headache	4/4
High blood pressure	11	Samoa spiritual issues	7.2	Stroke	205/139
Digestive problems	10	Respiratory (asthma, shortness of breath)	2.2	Backache	171/133
Anxiety	10	Psychiatry and behavioural	1	Oedema	8/98
Depression	8	Fever, malnutrition, influenza	0.6		

<sup>1</sup>Eisenberg et al (1999) [35]

<sup>2</sup>Mishra, Hess, Luce(2003) [8]

<sup>3</sup>Puckree et al (2002) [66]

Eisenberg's (35) research was undertaken mainly amongst American citizens and is slightly different to the research of Mishra et al (8) and Puckree, Mkhize, Mgbhozi and Lin (66), whose participants were drawn from underdeveloped areas and regions. Eisenberg's list (35) as shown in Table 2.1 contains mainly chronic diseases, while the other two lists contain both chronic and acute conditions. Puckree et al (66) express general concern about the medical conditions for which participants use unconventional medicine, as some of these conditions are life-threatening. This raises the question: do people want to visit unconventional health carers or is there no alternative as health services to manage these conditions are unavailable? Some illnesses, such as poisoning, are acute and life-threatening, so one would presume that clients would use whatever health assistance was immediately available. Chronic problems, such as hypertension, and anxiety-related problems also feature strongly in the lists of Table 2.1. These problems are never easy to manage from the medical side and have no quick fix. They also require some form of accountability from the client. It is of interest to note that in Puckree et al's (66) list, the unconventional management of venereal disease scores highly. Could this be related to the fact that Puckree et al's (66) participants were mainly indigenous Africans in whose culture venereal disease is linked to infertility, which is related to sorcery, and therefore beyond the realm of modern health care? In addition, fertility is important within African tradition. (43,44)

Mlenzana (19) and Zonke (3) comment on how difficult it is to define minor ailments, as what often initially appears to be minor, can become complicated and develop into a major ailment. The website, [www.boahc.demon.co.uk/ailments.htm](http://www.boahc.demon.co.uk/ailments.htm) (2012/08/29) defines minor health ailments as back pains, burns, colds, minor cuts, stomachaches, insect bites, nosebleeds and rashes. (67) McWhinney (68) and Barber (69) further describe minor ailments as ranging from back pain to diarrhoea and wind. Table 2.2 summarises McWhinney (68) and Barber's (69) minor ailments, and gives the Xhosa word for each ailment.

**Table 2.2: List of minor health ailments (68,69)**

<b>Minor ailment</b>	<b>Xhosa word</b>
Back pain	<i>Umqolo obuhlungu</i>
Colds	<i>Ukukhohlela</i>
Conjunctivitis	<i>Amehlo abuhlungu</i>
Constipation	<i>Ukuqhineka</i>
Diarrhoea	<i>Isisu esihambisayo</i>
Earache	<i>Indlebe ebuhlungu</i>
Headache	<i>Intloko ebuhlungu</i>
Sore throat	<i>Umqala obuhlungu</i>
Toothache	<i>Izinyo elibuhlungu</i>
Vomiting	<i>Ukugabha</i>
Wind	<i>Umoya</i>

The majority of so-called minor health ailments mentioned in Table 2.2 would rarely cause immediate death, unlike some of the illnesses mentioned in the lists of Mishra (8) and Puckree (66) in Table 2.1. McWhinney (68) and Barber's (69) list, which the researcher regards as also containing acute ailments, differs from Eisenbergs' (35) list which includes more chronic ailments.

Mlenzana (19) explored how 100 participants residing in Khayelitsha and Philippi and attending CHCs in the area understood minor health ailments. Table 2.3 lists the nine ailments most commonly mentioned by participants which could be treated at home.

**Table 2.3: List of minor health ailments that clients listed can be treated in the home (19)**

Ailment	Number of clients (N=100)	Percentage
Headache	39	39
Stomachache	28	28
Fever	15	15
Cough	10	10
Diarrhea	9	9
High temperature	5	5
Tuberculosis (TB)	4	4
Vomiting	3	3

Four of the minor health ailments listed in Table 2.3 are similar to the minor health ailments mentioned by patients in Table 2.1 and are also similar to McWhinney (68) and Barber's (69) list in Table 2.2. Mlenzana (19) was concerned that TB formed part of this list, as it requires medical attention including close monitoring of regular and correct drug compliance, as well as the patient's response to medication. Mlenzana (14) explains that, in Khayelitsha and Philippi, there are home-based carers who monitor TB medication in the TB patient's home and based on this, participants may have a perception that TB can be treated in the home. She warns that patients could receive confusing messages regarding the right approach to this curable disease, which requires close monitoring for the whole course of medical treatment. She recommends that the perception that TB is a minor health ailment be further investigated within the TB management strategies, at community level. (19)

It is of further interest to note that when Mlenzana's (19) 100 participants were examined by doctors at the CHC the common diagnosis was that they had minor health ailments. In further interviews with these participants, Mlenzana (19) discovered that they also reported

other serious illnesses, such as kidney problems, arthritis, epilepsy and uterus problems. Mlenzana (19) remarks that this is cause for concern and wonders how these serious conditions managed to slip through the hands of both doctors and clinical nurse practitioners. She quotes Malcolm (70) who raises concerns about the amount of consultation time that general practitioners have to spend with their patients. Malcolm (70) claims that the maximum time with a patient is ten minutes during which the general practitioner is expected to listen, take an accurate history, explore the patient's ideas, beliefs and concerns about their problems, carry out an appropriate examination, arrange tests/investigations, discuss and agree to a management strategy and safety net. This time constraint might be exacerbated by overcrowded CHCs. The risk of misdiagnosis which could occur due to limited time is high, and as a result Malcolm (70) has decided to increase the consultation times in order to better assist patients.

Mash et al's (16) concern regarding the nature of overcrowding in CHCs has already been mentioned. They note that amongst a sea of patients regarded as presenting with minor health ailments, there might well be patients with more serious ailments who might be either misdiagnosed or handled in a superficial manner. Table 2.4 gives the top ten ailments mentioned by the 100 participants who were interviewed by Mlenzana (19) regarding their ailments.

**Table 2.4: List of top ten illnesses mentioned by participants (19)**

<b>Top ten illnesses</b>	<b>Number of clients</b>	<b>Percentage</b>
Fever	19	19
Stomach-ache	12	12
Cough	10	10
Chest pain	9	9
Rash	7	7
Backache	6	6
Discharge	6	6
Sores/wounds	5	5
Pimples	4	4
Diarrhoea	4	4

Four of the top ten ailments in Table 2.4 are also listed as minor health ailments in Tables 2 and 3.

In Zonke's (3) study with 36 older people residing in Khayelitsha and Phillipi, a comprehensive list of health ailments that participants mentioned could be managed at home, was generated (see Appendix 4). They disagreed with the suggestion that their home

management strategies were appropriate for minor health ailments and maintained that in the past, the home was expected to contain all illnesses (minor and serious), due to scarcity and inaccessibility of health care services in rural areas. Table 2.5 provides a combined list of illnesses mentioned by older participants in the four FGDs that could be managed at home.

**Table 2.5: Common minor health ailments mentioned in all four focus groups (3)**

English version	Xhosa version
Colds and flu	<i>Ukhohlokhohlo</i>
Chest pain	<i>Ihlaba</i>
Earache	<i>Indlebe ebuhlungu</i>
Headache	<i>Intloko ebuhlungu</i>
Mumps	<i>Uqwillikana</i>

It is also important to note that the older women who were part of Zonke's (3) study left the rural areas approximately 20 years ago and were currently living with second generation family in the peri-urban area of Khayelitsha. Here, they were not given free rein to practise their healing vocation as the second generation uses CHCs for health care services, even for those ailments that the older people regard as minor. Clough (40) discusses how women repress their knowledge of healing to a preconscious level if they are not given space to continue to practise this healing vocation freely. Hence, it is assumed that these older women in Khayelitsha were experiencing a similar situation. Although they provide a list of ailments which they believe are manageable at home (see Appendix D), there are ailments on this list that Zonke (3) perceives as being too serious for home management.

For the current study, it was important to investigate how different the list of health ailments generated by the older Xhosa women residing in peri-urban Khayelitsha was to that generated by the older Xhosa women residing in the rural Eastern Cape. The latter are still regarded by their families as key decision-makers in health matters in the home situation. Some have the role and responsibility of being overseers of their grandchildren while the parents work in the cities, and yet others have become mothers and fathers to grandchildren whose parents have died of HIV and AIDS. So they have little in assuming an overseeing role for the overall health needs of these children.

Since 1994, PHC was rolled out throughout South Africa, including in the rural areas, such as in those of the Eastern Cape. It was, thus, expected that such care would provide people with general access to PHC and health services, and that such care would impact on what illnesses are managed in the home and what illnesses are managed in public health centres.

This study proposes the integration of the two systems, that is, the indigenous and Western health system, with the older people playing a key role in the management of minor health ailments in the home. Having said that, however, the University of Cape Town (UCT) (3,19) has already extended a caution regarding treatment at home and giving older women a pivotal role in the management of minor ailments. Before this happens, they caution, dangerous traditional/unconventional methods need to be identified and older women need to be discouraged from using these.

### **2.2.5 Dangerous alternative/unconventional methods**

Abrahams, Jewkes and Mvo (71) argue that advocates of Western medicine commonly attempt to show how dangerous indigenous health methods are. (43-44,72-77) Mkhize (73) accuses the Western industrial world of trivialising indigenous knowledge, including IHK, calling this a subjugation of knowledge which is close to brainwashing and is driven by a neo-colonialist agenda. Abrahams et al (71) suggest that in keeping with calls for an African Renaissance, there is also the need for a shift in emphasis from exploring what is harmful in IHK, to developing a greater understanding of IHK. Many researchers have called on scholars to study, validate and transfer indigenous knowledge (ethno-science) for the sake of younger generations. (3,7,8,30,46,78) There is a fear that the carriers of indigenous knowledge, including IHK, will die out without having transferred this knowledge to younger generations due to the breakdown of family units and the migration of younger generations to cities. There is the danger of losing this reservoir of knowledge. (43,44,72,74-77) Another challenge which relates to Abrahams et al's (71) concerns is around the stagnation or lack of progress of indigenous knowledge. Since the earliest colonisers interpreted the IHK of the Xhosa as the darkest knowledge, it has become hidden and practised in secret, thus limiting its chances of development. (78-81) Katzellenbogen (82) maintains that applied knowledge requires verification and that during this period of verification mistakes can be and are made. The researcher, being a health professional herself for the past 20 years, remembers many slips that occurred between the patient and the Western healer. During these periods of slippage and readjustment, many lessons were learnt. Unfortunately, in South Africa IHK has not been afforded the terrain to be practised openly, to make mistakes and to learn from those mistakes so that there can be further development.

Having said that, it is important to share that one of the conditions of the Human Research Committee for this study of IHK was that should any dangerous substances or approaches be identified they would be discouraged. In this review, the researcher would therefore like to briefly discuss some of the concerns raised by other researchers regarding potentially dangerous IHK practices.

Abrahams et al (71) explored indigenous healing practices and self-medication amongst women in Cape Town, South Africa. They conducted 103 interviews with women in a primary antenatal setting. Roughly two thirds of the Xhosa-speaking women followed IHK for themselves and their babies and reported having done this with previous pregnancies as well. Not being given medication from a Western health care facility was perceived to be tantamount to not being given any care at all, and it was this that influenced the women's choice of selecting another health provider. Many women believed that pregnancy was a 'delicate' time when a woman has to deal with a myriad of problems. These problems range from direct sorcery originating from neighbours or the girlfriend of the child's father who might have a grudge or be jealous, to ancestry neglect so that an appeasement of ancestors might be required. Some of these problems could lead to the death of the mother or the child. As illnesses originating in sorcery or appeasement of ancestors are seen by traditional people as being beyond the scope of Western-trained practitioners (7,40,49,50,71), these traditional women consulted with and used indigenous healers during pregnancy to strengthen themselves and the foetus, and after the birth.

Bland, Rollins, Broeck, Coovadia and the Child Health Group (83) who studied the use of traditional medicine in the first three months of pregnancy amongst rural South Africans have challenged the IHK approach. They suggest that while many illnesses may be successfully managed at home using IHK, these remedies are not without their hazards. They mention that enema use in KwaZulu-Natal has been associated with severe metabolic or organic dysfunction, including the acute onset of respiratory distress, abdominal distention and hypotonia. Electrolyte disturbances might be caused by water enemas, and mortality by renal and hepatic failure. They conclude that treating newborns or infants at home might delay seeking professional help for potentially life-threatening conditions, such as gastroenteritis. Furthermore, giving non-prescribed medicines precludes compliance with exclusive breast feeding (EBF) as defined by the WHO. (84) Exclusive breast feeding entails giving the infant no food or drink, not even water, apart from breast milk - including expressed breast milk - with the exception of drops or syrups consisting of vitamins or mineral supplementary prescribed medicines. (84)

Niehaus et al (85) explored the diagnosis of schizophrenia and other psychiatric disorders in relation to the culture-bound *ámafufunyane* and the culture specific event of *ukuthwasa*. Both terms are used by Xhosa traditional healers to explain aberrant behavioural and psychological phenomena. According to Niehaus et al (85) there is an apparent overlap between these two conditions and schizophrenic symptoms. Although *amafufunyane* seems to have similar characteristics to *ukuthwasa*, *amafufunyane* carries a far more negative

connotation and is generally used to describe a young person with schizophrenic symptoms. *Ukuthwasa* on the other hand, is assigned to married people and is seen in a far more positive light. The concern of Niehaus et al (85) was that although these two conditions have similar symptoms, intervention with *ukuthwasa* might be delayed due to the way it is defined and seen in a more favourable light. They conclude that the positive connotations associated with *ukuthwasa*, as opposed to the more negative connotations of *amafufunyane*, may have implications for the treatment and prognosis of schizophrenia and needs to be clarified.

The study by Niehaus et al (85) coincides with a study by Mbanga et al (86) on the attitudes and beliefs of Xhosa families towards schizophrenia. They found that although 88% of Xhosa families used psychotropic medications, 32% of this group believed that schizophrenia could be cured by traditional healing methods, and 30% used traditional rituals. Niehaus et al (85) conclude that a number of worrying perceptions exist amongst patients and their relatives, for example, some believed that there was only cause for concern when the patient has defaulted for over a month in taking psychotropic medication. They warned that clinicians who work with Xhosa-speaking patients with schizophrenia and their families would do well to be aware of traditional attitudes and beliefs towards this illness and to make an effort to determine their explanatory models. They further assert that psycho-educational programmes need to address such explanatory models and that clinicians need to negotiate a shared biomedical model which they perceived is likely to foster a therapeutic alliance and promote adherence to treatment.

Dagheir and Ross (87) studied the approaches used by traditional healers regarding the treatment of cleft lip and palate. Interviews were conducted with 15 traditional healers who claimed to have each been exposed to and had treated one to six persons with cleft lip. Most of the healers believed that cleft lip was caused by ancestors, spirits and witchcraft. Treatments included the use of thorns, bleeding, incantations, needles and asking for the sacrifice of a goat or chicken, or the avoidance of certain foods, such as rabbit meat. Dagheir and Ross (87) cite Hammond-Tooke (88), who noted that many herbalists have a very good knowledge of many natural substances that have a real remedial effect. Seventy-three percent (73%) of the participants maintained that they needed further input from Western approaches to improve their management skills of this condition. They end their paper by recommending that sharing information on cleft lip and palate treatments needs to be done in a culturally-sensitive manner. (87)

Lewis, Rudolph, Mistry, Monyantsi, Marambana and Ramela (89) studied the oral health knowledge and practices of African traditional healers in Zonkizizwe and Dube, South Africa. They examined the self-reported knowledge and practices of 83 traditional healers. Forty-

eight (48%) of healers kept written records; and more than 91% correctly recognised gingival inflammation, dental caries and oral candidiasis. Over 50% of healers referred patients to practitioners in the formal health care sector. The vast majority of healers gave oral health advice to their patients, and many of them

gave specific toothbrush instructions. Forty per cent (40%) of the traditional healers gave patients *muti* (traditional medicine) to use as a rinse for the treatment of oral candidiasis and 18% prescribed combinations of salt, snuff, glycerin, sugar and bicarbonate with which to rub or rinse. Two healers spoke of treating dental caries by removing the 'worm' which causes decay and giving the patient *muti* to rub on the tooth and then having the patient inhale smoke. The authors expressed concern about information shared by traditional healers on how patients are treated by Western doctors. They maintained that patients often leave the doctors not understanding exactly what is wrong with them or how they should use the prescribed medication. They are also scared to ask questions. Maleana and Lidell (43,44) recommend that traditional healers and Western health professionals should spend more time with each other to learn about their different cultural beliefs and practices.

Eshete (90) found that in many parts of the developing world a large proportion of fractures continue to be treated by traditional bone setters, who are easily accessible and often have a good local reputation. There are usually no mainstream medical facilities and patients often travel as far as 300 km to receive specialist surgical attention. Many arrive on the back of fellow villagers, as road transport is rare. While many fractures do heal properly with traditional treatments, bone setters are often unaware of the dangers of tight splinting, which can cause gangrene and eventually necessitate amputation. Eshete's (90) study found that in one year in Southern Ethiopia, 49 amputations were performed, of which 25 resulted from the tight splinting of bone setters. The traditional bone setters often use splints from bamboo or strips of wood that are tightly bound around the limbs, and occasionally also the joints. Unfortunately, these splints are not removed when pain increases, thus a compartment syndrome with its complications or death of tissue and gangrene may follow. Death may result when complications such as tetanus and septicemia set in.

Eshete (90) arranged workshops to assist the traditional bone setters to gain an understanding of the precautions to take with splinting, and to become more aware of some of the complications of bone setting. In the beginning, people were afraid to declare that they were in fact bone setters. Some feared that they would be stopped from practising their vocation and consequently not earn an income, while others feared purging. However, with the co-operation of local leaders and a one-day training programme, Eshete (90) maintains that they have decreased the problems of gangrene from bone setting by half, and this also

includes amputations that are related to bone setting complications. Thus Eshete (90) concludes that the incidence of gangrene related to traditional bone-setting can be reduced with education and awareness.

Puckree, Mkhize, Mgobhozi and Lin (66) consulted traditional healers regarding physiotherapy-related illnesses. They reported that some patients visited traditional healers for conditions that were regarded as life-threatening, for example, chest conditions, poisoning, stroke and fractures. Other conditions that patients visited traditional healers for included a 'chesty chest' (chest with secretions), traditional vapour baths, heat therapy for aching body pains, and massage with ointments, all of which are similar to physiotherapy modalities. Puckree et al (66) conclude that despite the popularity of traditional healing, it has remained marginalised, poorly regulated and unsubsidised. The lack of subsidisation could cause a drain on the meagre resources of those rural families who lack access to health services and have to resort to consulting traditional healers, and for poor families who choose to visit a traditional healer. (66)

To conclude this section, it is important to mention that the decision to consult a traditional practitioner is not made lightly by patients and their relatives. (8,65) The majority of patients, when confronted with a medical problem that appears beyond the scope of home remedies, would prefer to first seek medical help when it is available. (3,20,21,45) However, some patients report that the type of medical care they receive is often unhelpful, and this is why they opt to see traditional healers. (3,20,21) There is a strong call for health professionals to be more empathetic, to give clear and consistent explanations about illness and treatment, and to refrain from criticising patients who have tried traditional medicine. (7,35,48,78) There is a call for Western health care and traditional healing to reconcile, with the hope that the veil of secrecy that exists regarding IHK and its practices will be lifted so that both sides could benefit from understanding the other's approach. (57,49,71) Ironically, when one examines some of the approaches used by indigenous healers, they are not far off from some of the initial approaches used by modern health care. IHK has not been afforded the opportunity to develop, as it is practised in secret. Empowerment is one of the key elements of PHC, and by recognising the existence of IHK as an asset and helping it to develop, would benefit both modern and traditional health care.

### **2.2.6 Summary of Section 2.2**

This section began by presenting the 1948 WHO definition of health, which has been criticised for not being comprehensive enough. The health definition of the Indigenous Peoples of the World was also provided and it was suggested that the two health definitions

should be integrated to bring about an overarching definition of health that includes insights from the Indigenous Peoples of the World.

Health belief models were described within Kleinman's Cultural System Model which covers the popular; the folk; and the professional arena. It was noted that rural South Africans swing between the three arenas, due to a lack of availability of health services. Maena and Liddell were drawn on for a review of African health belief models. Malena explains that traditional Africans do not believe in chance, bad luck or fate. They believe that every illness has a specific intention and a cause. This was supported by Liddell in his description of three categories of illness in Sub-Saharan African culture. Both authors emphasise the need to consider African beliefs and practices when dealing with rural African people.

A description of the home was given, showing that it is where illnesses are declared and contained, with the older women being seen as the maintainers of health and the containers of ill-health. Problems commonly managed by alternative approaches were listed. It was also noted that in America, alternative approaches were used mainly for chronic illnesses whereas in South Africa some life-threatening conditions are treated with alternative approaches, such as snake bite poisoning. A question was raised about whether alternative approaches were used because of the lack of access to health services.

Lists of what people perceive to be minor health ailments were presented, however it was noted that it is difficult to classify minor health ailments, as what is regarded as minor could easily complicate into a major health ailment.

This section concluded with a consideration about what could be regarded as dangerous alternative methods. It questioned some perceptions that IHK was dangerous, explaining that it has tended to be practised in the dark and has lacked the opportunity of being researched and scrutinised. The study reminds us that some of the early biomedical approaches too seemed to be barbaric, when compared to the new approaches that have replaced them. It would appear that there is a need to understand what IHK really is.

### **2.3 INTRODUCTION TO INDIGENOUS HEALTH KNOWLEDGE (IHK)**

This section covers IHK systems in Southern Africa. It provides an overview of Southern African indigenous health management strategies with the main focus being on the management of psychiatric illnesses. Different perspectives are presented regarding the worldwide perspective underpinning IHK. The section concludes by highlighting the need for further research into IHK.

### 2.3.1 IHK systems in Southern Africa

Unlike the literature already presented (7,36), the literature that explores the perceptions of the people of Southern Africa regarding their ideas of health and wellness is minimal, with most of the available literature focusing on the actual illnesses of individuals. (46,52) This might be related to the patient-clinical health professional interaction that occurs. Professionals tend to be both researchers and writers and tend to be based in those medical institutions where ill individuals come to present their illnesses. Abrahams (71) is of the opinion that in Southern Africa, studies into IHK revolve around the harm it does to patients. This means that there is minimal literature that depicts IHK as evolving and contributing to evolving knowledge of health that also requires research with the aim of improving it. (7,8)

This section of the literature review concentrates on perceptions of illness of people residing in the southern part of Africa, with a specific focus on the Xhosa tribe.

In the Eastern Cape of South Africa, where the early European settlers and missionaries first encountered Xhosa diviners and their traditional healing practices, these practices were considered as the mainstay of the grossest darkness of humankind. (43,71) In the nineteenth and early twentieth centuries, Western health care, in the form of tropical medicine, focused mainly on major epidemic diseases such as variola, cholera, and plague, as these flourished in the tropics where there was very poor hygiene. The development of bacteriology and serology yielded prophylactic means to prevent these dangerous diseases. (30) Nowadays, most of these quarantine diseases are a thing of the past.

In the second stage of Western health care the focus turned towards chronic endemic diseases, such as yaws, leprosy, malaria, venereal infections and filariasis. Prevention of this group of diseases was often approached by way of mass campaigns, so much so that in the case of malaria the mosquito became more important than the patient. This second stage was characterised by poor communication. Jansen (30:2) cites the missionary doctor, Cicely Williams (1958) who remarked that, "The basis of these campaigns is usually to devise measures that demand population acceptance rather than active co-operation"; and with a touch of humour she added to this, "Let us pray for your house that this will prevent malaria, let us give an injection, this will cure your syphilis and your yaws, let us inoculate you, this will protect you from tuberculosis".

The greatest challenge faced by missionaries, who were both medical personnel and educators, was how to overcome the resistance to the introduction of Western medicine amongst the indigenous Xhosa population. The Western doctor would typically brush off his indigenous patients and did not pay sufficient personal attention to them. Being overworked

and overburdened did not help the situation. This lack of attention, according to Jansen (30), is what caused the indigenous patient not to trust Western medicine. Jansen (30:2) expands on this idea by saying:

The crisis in western medicine is that investigations concentrated upon certain mechanisms, upon special organs, and systems to good purpose. The patient was provisionally ignored: he was merely the incidental battle field of bacteriological conflict, or irrelevant container of a fascinating biochemical process.

This perception is further expanded upon Bùhrmann (32:19):

We are getting too one-sided in our development of the rational side of our being and thus getting psychologically impoverished and also severed from roots which nourish us. How can we claim to be healers when we have become technologists? Especially healers of people to whom technology has less meaning and the human being is still supreme? This might be partly because western technology is moving away from the essence of being human and from participating creatively with the rest of the world. The Xhosa healer is not only essential for his own people, but to some extent for all of us.

Buhrmann (32) was not far off the mark - indigenous people saw biomedicine and the modern world as having made a big mistake by ignoring IHK systems. (7)

### **2.3.2 Southern African IHK management strategies**

Berg (49) estimates that up to 80% of South Africans consult traditional healers. The University of Cape Town (UCT) has attempted to bridge the gap between the traditional and Western biomedical approaches through the publication of the *South African Primary Health Care Handbook*. The focus of this book is on physical diseases and their treatment. Berg (49) explains that if it is true that traditional healers seem to work most successfully with psychological and psychosomatic illnesses, then it is imperative for psychiatrists and mental health professionals to understand the psychological mechanisms through which healing takes place.

Recent South African writings on mental health, from a postmodern political perspective, show that the stereotyping of African culture was part of an abusive system, with disastrous effects on the health care system in South Africa. (91) Berg (49) argues that ancestor reverence, as mentioned in Maelene (43) and Liddell (44), has a deeper meaning and embodies Xhosa traditional healing methods, however, this core concept is often mentioned only fleetingly by writers in the mental health field such as Swartz. (91) Berg (49) mentions two exceptions, namely, the work done by Madu, Baguma and Pritz (92) in the World Council

for Psychotherapy-an African Chapter; and the pioneering work of Vera Buhrmann in the 1970s and 1980s. (93-98)

At that time, Buhrmann was the only Jungian analyst in the country and Berg (49) maintains that her work is becoming more relevant in the current South Africa where there is a sense of urgency for the African world view to be respected. Buhrmann (in Berg) (49) echoes the insights of Maelene (43) and Liddell (44), who warned that failure to do this has had disastrous consequences. Berg (49) maintains that we need to understand issues related to ancestor reverence and IHK in general, as well as approaches to psychosocial illnesses, in particular.

Traditionally, Southern African IHK management strategies involved ancestor reverence, particularly in healing psychosocial illnesses. People consulted traditional healers who were highly-trained therapists and who used the physical structure of specific traditional rituals in the healing process, for example, drumming and dancing. There was family and community involvement, and last but not least, dreams were key to the process of healing.

### **2.3.2.1 Ancestor reverence**

Ancestor reverence is a way of understanding the world; it is not a religious system. Christianity and ancestor reverence can and do co-exist, where *ancestors are revered* and *God is worshipped*. This important fundamental distinction escaped the missionaries of the past who talked about 'ancestor worship' as 'lapses into heathenism'. It is this European prejudice lodged in the subconscious of the Western psyche that could account for the reluctance to look at the practice of ancestor reverence from a positive, constructive point of view.

The notion of ancestor reverence pertains to the general belief that something of the dead person does not wholly disappear; that something survives and is given substance by respecting those who have died. As already mentioned when discussing IHK, humanity, in the context of African thought, includes not only of the living. The dead play a very important part in the whole universe of forces and continue to interact causally with the living. The ancestors are the 'living' members of the family and clan who have died, but who continue to live on as 'shades'. There is a live, human, relationship between the individual and his/her ancestors - the ancestors act as guides and mentors. *Their presence is the main factor in maintaining good health*. They are omnipresent and their influence is benign and all-embracing. There is a symbiotic relationship between the ancestors and the living - with the living keeping the deceased in mind and honouring them through ceremonies, and in return receiving their protection. (49)

### **2.3.2.2 Highly-trained traditional healer therapists**

A majority of traditional healers are highly trained therapists. The English word 'witchdoctor' is an unfortunate one. It belongs to the genre of colonial literature, evoking exotic images of cunning darkness. Berg maintains that Hammond-Tooke (49,88) rightly argued that it is perhaps necessary to place an embargo on the use of this term. The extensive training traditional healers undergo has been described by Bührmann. (97) Over a period of several years, candidates are initiated in a process that requires rigorous preparation and ancestral approval. Healers should thus be regarded as the equivalent of skilled psychotherapists. Berg (49) further explains that African philosophy and thinking is rooted in two fundamental concepts: *ubuntu* and ancestor reverence, with the former being an African word depicting humanity and compassion.

### **2.3.2.3 Ancestor reverence and psychosocial illnesses**

The application of ancestor reverence to psychosocial illnesses is prevalent in indigenous healing strategies. The individual is linked through his/her clan to the ancestors. Rituals are performed at important points in the person's life cycle or at any other times when there is a need. Through these rituals the communion, the link with ancestors is re-established. The ancestors are heeded and respected through rituals and in turn they act as protectors, mentors and guides for the individual. Should they not be attended to, they withdraw their protection. It is in this lack of connection, this broken link, that the individual becomes exposed to the powers that have an opposing effect to one's health. In psychoanalytic language it could be said that by paying attention to the subconscious the individual's ego functioning is strengthened. If the subconscious is ignored, the ego becomes brittle and may decompensate and succumb to negative forces within the psyche. If things are going well for the individual, the ancestors may remain in the background of consciousness, but if not, they manifest themselves through dreams and bodily sensations, or even illness. (94) A ritual may then have to take place in order to re-establish the connection between the individual and his/her ancestors.

### **2.3.2.4 The use of rituals in promoting health and preventing illness**

Berg (49) quoting Hammond-Tooke suggests that rituals are the techniques that humankind has devised in order to manage satisfactorily their relations with gods, nature and their fellow beings. In African tradition, there are no set collective times for rituals as in the liturgical calendar year of religious systems. The occurrence of rituals is individually determined and three types of occasions are noted:

- a. the life cycle rituals of birth, initiation, marriage and death;
- b. rituals to thank the ancestors for the successful accomplishment of a task; and

- c. rituals for when illness strikes. Berg (49) describes the four aspects (*intlombe*, drumming and dancing, dreams and reverence of ancestors) that form part of most ritual happenings and that serve to illustrate how these facilitate the important psychic function of making links with the ancestors, to promote health and prevent illness.

### **2.3.2.5 *Intlombe - the physical structure of the ritual***

Berg (49) explains *intlombe* as a Xhosa dancing that is performed as a ritual indoors. There is a basic four-ringed structure, formed by the walls of the hut or the house, the circle formed by the family and community, the circle formed by the dancers, and the centre place which is the hearth, the place of warmth and food.

This basic structure forms the framework within which ceremonies of different types are performed. Bùhrmann (97) observed that this structure is that of the universal mandala, with two non-human and two human circles as the basis. The word 'mandala' means 'circle' in Sanskrit. Mandalas are usually made up of several concentric circles that are there to "shut the outside and hold the inside together". (98:630)

The basis on which healing occurs is through two fundamental, early psychic processes: establishing links; and containment. Berg (49) maintains that these have been formulated in the language of objective relations. Bion (99) describes the containment which the mother provides for her infant and how within that containment, the link between inner objects is enabled. In the language of analytical psychology it could be said that the mandala structure provides the template, within which the union of the opposites, can take place. (97)

When there is psychic turmoil, the individual needs the containment above all. It is well known in analysis that dreams with mandala images appear at a time when there is upheaval in the dreamer's inner or outer life. Jung (98) showed in numerous case studies how mandala images appear in spontaneous drawings of patients of various ages and noted the ordering and containing effects that these presentations have. In traditional African culture, this containment is externalised and made concrete through the structure of the ceremony. This offers an emotional holding in which the outside is shut out and the focus is on the inside.

### **2.3.2.6 *Family and community involvement***

Consultation with a healer is never done alone. The patient is always accompanied by at least one significant other. Rituals are always performed with members of the affected individual's family and people from the community. The *intlombe* can be regarded as a special form of group therapy. Berg (49) quoting Nqweni (100) compares the African *intlombe* with Western group therapy processes.

What distinguishes the African group is that there is a relationship between members in the group - they are usually family members, actively involved in the life of the person for whom the ritual is being performed. This is a manifestation of a unified concept of the individual, in which she or he is not isolated, but part of others and is quite unlike Western culture, where the developmental goal is separation from the family to become an isolated individual.

The function of the healer is also different from that of the Western group therapist. The healer conducts the *intlombe* in a directive manner and has a mandate, and indeed is required to give directives. The mandate enables the healer to give direct advice to members of the group. This is because the healer is functioning as a mouthpiece for the ancestors and his/her authority is vested in this. The communication thus takes place not only on a conscious or personal object relations level, but also on a primordial, archetypal level. The linking that occurs is between the individual and the community, and between the individual and the ancestors. This is further enhanced by the active participation of the body in the group process. (100)

### **2.3.2.7 Drumming and dancing**

Amongst Xhosa speakers no ritual occurs without the participants drumming and dancing. The dance is called *xhentsa* and consists of a special rhythm and stamping beat, with the bare feet of dancers pounding into the earth in a slow, regular and firm manner. Dancing occurs in the group setting and with others who move in an anti-clockwise direction around the central fireplace, and is an activity that focuses on the internal world of the dancer. (96) The participants are preoccupied with themselves in an intense manner - *they think and sing about their illness*, talking about it and about their ancestors. (98)

A further function of the *xhentsa* is the activation of the body through vigorous movements. According to Damasio (101), it is well-known that endogenous opioids are produced with exercise, and these in turn have a direct effect on the individual's sense of well-being. The rhythmical aspect of drumming and dancing requires more in-depth thinking. Berg (49) mentions Damasio (101) and Maillo (102) who examined the rhythmical dimension of the mother-infant relationship, and makes the point that rhythm forms part of the human being's procedural knowledge and memory, and is part of primary development. She writes about the function of a regular rhythm as being the constancy and reliability (which) may be indispensable ingredients for the establishment of basic trust. The ability of the ritual tend to give a containing effect through a physical structure and is thus further enhanced by the auditory and bodily component of the rhythmical beat.

### **2.3.2.8 Dreams**

Berg (49) explains that dreams move one from the physical container, the group and the body, and attention is turned to the inner-most process, namely, that of the dream. No meaningful in-depth psychotherapy in Western culture occurs without having tried to give an interpretation of dreams. However, dreams generally do not form part of everyday, shared ordinary life.

In the African world view, dreams are very much part of everyday life and not dreaming may become a serious problem and could be a reason for performing a ritual. "The dream is to see the truth at night ... the dreams are the truth because ancestors never deceive their children." (96) Dreams are regarded as messages from ancestors. They have both therapeutic and prognostic value. Although the actual symbolism contained in the dream is usually not analysed in the way it would be in Western psychotherapy, the dream is fully experienced and its message is acted upon. The 'royal road to the unconscious' is here travelled with a seriousness that is often missing in European culture. The role of traditional rituals is to help the person to dream, to share the dream, and to find the meaning in the dream. For this the healer's knowledge and skills are needed and he/she is the link to the ancestors.

To conclude, Berg (49) maintains that traditional rituals have a positive effect on mental illness because they address the fundamental human need of establishing links. In the African world view, disconnectedness can cause profound suffering as well as ill-health. Through rituals connectedness is re-established, links are made between the individual, the family and the community, between body and mind. All of this occurs within a ritual space that is presided over by the healer who has been trained and acts on behalf of the ancestors.

### **2.3.2.9 Psychological position of ancestors**

Berg (49) concludes that ancestors are fantasies about images of the ancestors and are projections from the collective layers of the unconscious. It is this deep layer of the unconscious which is the realm of the archetypes, which connect us all as human beings. This idea was initiated by Freud (103) who intuited its existence when he wrote about the primal fantasies as our phylogenetic endowment. Jung (98) expanded on this work. The collective unconscious is part of the psyche which can be negatively distinguished from the personal unconscious by the fact that it does not, like the latter, owe its existence to personal experience, and consequently is not personal acquisition. The collective unconscious is made up of archetypes which are unconscious images of instincts; and hence universal to all humankind. The human endeavour is to integrate unconscious forces into the ego, the centre of consciousness. The realisation that the ego is but a small part of a whole is in keeping with

Freud's revolutionary discovery of the power of the unconscious. Adding the collective unconscious takes this one step farther.

The archetype of wholeness - what Jung termed the 'Self' (98) - occupies the centre of the collective unconscious. It is a symbol of unity and wholeness, what in traditional religions is understood as the concept of God, the imago. Jung (98) posits the notion of a hierarchy of archetypes with the Self being in the highest position, but requiring the realisation and help of the lower archetypes in order to obtain this shadow, animus/anima, or wise old woman. If some of these were translated into Judeo-Christian concepts, we would call them angels, or the messengers of God, the self-possessing numinous qualities that is, extraordinary, compelling supernatural power. Berg (49) hypothesises that the ancestors occupy a midway position between the ego and the Self. Ancestor-reverence is often misunderstood as threatening traditional religions and is misperceived as religion per se. This misunderstanding is based on the erroneous equation of the ancestors as 'God'.

Berg (49) concludes that much harm has been done by those local churches in South Africa that forbid the ritual honouring of ancestors on the grounds that these are 'pagan' rituals. This has led to a rupture from the roots of a very old, profoundly meaningful healing cosmology. The traditional ceremonies that were discussed earlier on are a manifestation of the human need to find a way in which to honour the unconscious and to find meaning. In a traditional African culture this is done through the belief system which reveres the ancestors, who in turn act as intermediaries to the higher being. The notion of a collective unconscious and the concept of the archetypes form the basis of culture, health and illnesses. According to Berg (49), the only real understanding of the health-seeking behaviour of patients is a psychological interpretation which explains the deep desire of individuals to acquire a genuine respect for each other, despite cultural differences.

### **2.3.3 Worldwide perspective on IHK**

#### ***2.3.3.1 IHK of the aboriginal people of Canada***

Cook (17) studied the aboriginal people of Canada, wanting to determine why patients who attended a First Nations Community Health Centre were using traditional Mi'kmaq medicine. (2005) He maintained that no culture can claim a monopoly on healing, but that diverse healing systems have developed throughout the world. Although they differ greatly in their methods, these systems are based on a common goal of maintaining the human condition in a good state of health. Unfortunately, when Western medicine comes into contact with IHK there is often conflict. For example, the practices of the indigenous people of Canada endured significant insult during the process of European colonisation. (17) This situation is

similar to the attitudes of health professionals at CHCs in Khayelitsha as described by Gessler (18), Mntwana (19), Zonke (3), and Keraan (20).

Cook (17) found that the Canadian Indian Acts of the late 1800s were associated with legislation that denied access to traditional plants for medicinal purposes and that banned traditional healing methods, describing them as witchcraft. He describes how the Grand Chief of the Nations of Ovide was convinced that one of the reasons for health problems in their community was because of the destruction of their original culture. For Cook (17), it is important that instead of resisting the restoration of the Indian indigenous culture, the medical profession should become a partner in it. According to the indigenous Indian people, the integration of traditional healing practices and spirituality into national medical and social services are the missing ingredients, if those services are to work for indigenous people.

According to Cook (17), the Society of Obstetricians and Gynecologists of Canada's Aboriginal Health Issues Committee recommended that health professionals should respect traditional medicines and work with aboriginal healers to seek ways to integrate traditional and Western medicine. They asserted that health professionals should appreciate holistic definitions of health as defined by the aboriginal peoples. In her study, Cook (17) showed that participants use traditional medicines in addition to Western medicines, but that this is generally not discussed with the physician. Cook's (17) findings are similar to those of Fink (52) who found that only 1% of patients in Madagascar reported having used other medicines prior to coming to the Health Care Centre. These findings resonate with the findings of other researchers regarding the reluctance of patients to disclose what they have used prior to visiting a health centre. (3,16-18,48) Furthermore, a large percentage of these patients believe that traditional medicine is more effective than Western medicine. (17) Cook (17) shows that her findings are similar to the findings of studies done with urban American/Alaskan native patients, in which 70% of respondents claimed to often use traditional health practices for conditions like alcohol abuse, trauma and musculoskeletal pains. Historically, these illnesses have been less successfully addressed by biomedical interventions. (16,48) The traditional Mikmaq believe that on this earth for every illness there is a medicine under your feet. However, the counterpart to this belief is that 'the white man's diseases often require the white man's medicine'.

It is important to acknowledge that there are strengths and weaknesses in both the traditional and the Western systems of health, however understanding the attitudes towards traditional healing practices is a key part of understanding the context in which patients live. Integrating the best of both healing methods will provide the most effective and respectful care for patients. (16) Unfortunately, as already discussed, many studies have described the

unacceptable attitude of practitioners at health centres towards patients who disclose their usage of traditional medicines. (3,16-19,48) This diminishes the opportunity for an open dialogue between patient and health care provider and undermines the possibility of delivering a more integrated and comprehensive health care service, based on respect for different beliefs and methods. (48)

### **2.3.3.2 IHK of Native Americans, USA**

In January 2000, the National Centre for Complementary and Alternative Medicine (NCCAM) in the USA launched a programme to study the methodological feasibility and scientific rationale for the use of traditional, indigenous systems of medicine practised in the USA, prior to proceeding with full-scale clinical research trials. More recently WHO released a report on policies and strategies to implement traditional medicine. (32,105) The main thrust of these efforts is to remove health disparities amongst different segments of various populations. (7) According to Struthers (48), there is little documentation of the IHK of traditional Native American healers, and formal research into their healing ceremonies is almost non-existent. Several factors contribute to this reality (7):

- a. People who use traditional indigenous practitioners rather than medical practitioners, fear ridicule.
- b. There is concern about how information will be used if divulged.
- c. Healing might be considered a private matter.
- d. Traditional healing is considered sacred.
- e. Healing practices are documented orally and thus remain unwritten.
- f. The scientific community views education (of the researchers) and physical evidence, as the hallmark of truth and proof, and the perceived lack of education of healers, combined with the more metaphysical/natural elements of traditional indigenous medicine, do not fit within the narrow scope of the standard parameters of modern science and medicine.

It is interesting to note that according to Struthers (48), advanced science and technology were expected to assist Americans obtain an elevated level of wellness, but health statistics, including high levels of violence, show otherwise. Holistic traditional healing, unlike fragmented mainstream healing, recognises these increases in the levels of violence as disturbances in balance, which have a direct impact on the health status of the American people. (7)

Struthers (48) cites a contemporary Native American healer, Thunder Woman, who argues that traditional healing is the original medicine, and that Western medicine is the alternative

practice. The healing traditions of Native Americans have been practised on the American continent for 12 000 years and possibly more than 40 000 years, depending on which theory of origin or arrival one espouses. The term 'medicine' can be traced back to at least the seventeenth century in Native American cultures. French Jesuit missionaries amongst the Huron, Montagnais, Ottawa and other inhabitants of New France, documented and described traditional healers using the term, 'home medicines' (medicines is the French word for doctor). The medicine of Native Americans was described as mysterious or as containing wonderful power or efficacy in Indian life or belief. Thus the term 'medicine' in Native American cultures has come to mean 'supernatural power'; and from this, terms such as medicine man, medicine women, medicine bag and good medicine versus bad medicine are derived. (48)

Although the methods of diagnosis, methodology and treatment may vary greatly from tribe to tribe and from healer to healer, depending on the various climate and food supplies of the region, a fundamental principle of all Native American cultures is wholeness and interrelatedness. The art of traditional healing places emphasis on the spirit, supernatural forces and beliefs/religion. Everything is intertwined and impacts on other things - thus the sum of the whole is greater than the parts. Their traditional indigenous healing *includes health promotion and prevention*, and at the core are practices and rituals which maintain balance and prevent illnesses.

Struthers (48) identifies seven categories of techniques used by Native American healers to restore imbalances. These vary in complexity:

1. *Dreams*: Dreaming of events to foretell the future.
2. *Natural elements*: Water, fire, smoke, stones or crystals.
3. *Direct interaction*: Prayer, laying on of hands, chanting, talking and counseling.
4. *Ceremonies*: Using music, dance, singing, drums and rattles.
5. *Smudging with medicinal plants*: For example, sage, cedar or sweet grass.
6. *Medicinal plants or botanical medicines*: Teas, salves, ointments or purgatives.
7. *Specific venues*: For example, sweat lodge, shake tent, Yuwipi.

Traditional Native American healers are few in number and thus the demand for their services exceeds the supply, and patients are prepared to explore, investigate and travel to find healers. However this is done with caution because of charlatans. The term charlatan is used for a person who pretends to be something she/he is not and in this study and this context relates to those that pretend to have an understanding and knowledge of the scope of practice of IHK when they do not, in fact, have said scope of practice. (48) Usually healing ceremonies are attended by the family and community, with the ill person being at the centre

of the ceremony. Thus the person feels the unconditional support that has been granted with the sole purpose of improving his/her situation and this in itself has a positive impact. This is similar to Bùhrmann and Berg narration of the Xhosa scope of practice of IHK. (32,49,94-97) The person usually gives a traditional healer tobacco to thank him/her for the consultation and sometimes money is offered. Table 2.6 presents a detailed comparison of traditional Native American healing and modern Western medicine, as described by Struthers (in Hollow, 147) (48):

**Table 2.6: Comparison of traditional Native American approach versus Western medicine (48)**

<b>Traditional Native American healing</b>	<b>Modern Western medicine</b>
Mind, body, spirit, holistic approach	Reductionist approach
Patients' tribal beliefs of health and illness used along with physical, social and spiritual data to make diagnosis	Reductionist data-biochemical physiologic anatomic, laboratory data - used to make diagnosis (social and spiritual not emphasised)
Teaches (via healer) patient to heal self	Medical doctors do the healing
Ceremonies teach the patient how to be well	Teaches patient to depend on the medical system and remain ill
Health and harmony emphasized	Disease and caring emphasized
Honours the patient for restoring wellness	Honours the physician for curing
History, physical examination and family assessment used along with treatment plan	History, physical examination and laboratory data used for treatment plan
Herbal medicine from nature may be used	Pharmaceuticals may be used
Preventative medicine taught to patient and family	Preventative medicine taught to patient and family

Struthers (48) mentions that there are Western-trained physicians who are beginning to respect traditional Native American healers and who perceive them as colleagues who are on the same or a higher level as themselves. They recognise that many community members chose to consult with these traditional healers rather than Western-trained physicians because of their approaches and beliefs. Struthers (48) concludes that many people desire more holistic methodologies to regain and/or maintain a healthy state and that whatever their preferred healing system, the ultimate goal is an integrative approach so that clients can use both systems of health care. (17)

### **2.3.3.3 IHK in Mexico**

Whiteford (104) explored patterns of medical choice amongst working class families in the city of Oaxaca, Mexico. The study examined illness and health by way of a series of open-ended interviews with 94 women. A picture of how illness and health are defined and the

methods for addressing health-related problems began to emerge. These women saw the state of well-being as positions along a metaphorical continuum, ranging from being healthy to having illnesses. Thus the ill person is not someone who has been infected with something radically different from the individual who is well. In contrast to a healthy individual, the ill person occupies a slightly different position in the gradient of well-being. For many of these women the biomedical explanation for illness is too simplistic, incomplete and inaccurate. (104)

#### **2.3.4 The link between IHK and this study**

In 2005, Mlenzana (19) commented on the complex relationship between health professionals and their clientele. She highlighted the multiple dimensions of health mentioned by Fry (52), Denhill et al (105) and Niven (106) and pointed out that the way we lead our lives will affect our health both directly and indirectly. The community health forums that discussed the problem of overcrowding at CHCs in Khayelitsha also recognised the complexity of health-seeking behaviours, which they understood in the context of rural-urban migration, broken family units, and lost traditions. They also drew attention to the scarcity of community-based resources, such as the IHK carried by the older people. Their interpretation of health-seeking behaviour does not fall far from that of the Indigenous Peoples Worldwide. (7,8)

Traditional knowledge is an important part of South Africa's cultural heritage. Before the development of synthetic chemicals, plants were an important source for the ingredients of medicines. They were also used as a source of food and as material for equipment. Wherever European cultures colonised the world, this indigenous knowledge went underground and was practised in secret. (32) However, South Africa cannot afford to embrace an exclusively Eurocentric medical approach. This notion is supported by Buhrmann (32), who asserted that the concept of 'community involvement' implies that health care is not only the responsibility of external agencies and specially trained health practitioners or the family physician, but that the whole community has a responsibility to ensure that the health of every member is maintained at optimum level. She argues that health in many preliterate societies and even the survival of the group as a whole would depend on the ability of all individuals to fulfil their roles, as well as the knowledge of healing that was passed from generation to generation. The challenge facing us today is to make the descendants and the owners of this huge reservoir of traditional health knowledge and medicines, once again proud of it and confident enough to share it. (29)

In Mlenzana's (19) study, only 6% of older people who visited the CHCs presented with minor health ailments. Mlenzana (19) postulates that the reason for this low percentage

might be that some older people living in Khayelitsha and Phillipi are still using their IHK. Zonke (3) supports this view, but raises concerns regarding the retention of this knowledge which will be lost as the older people die out, without having documented or passed on their knowledge. In recent years traditional healers have been recognised and are collaborating with medical practitioners in managing and delivering PHC. (29) However, there has been silence about the role older women played in the care of health problems in the home.

This study has posed, *inter alia*, the following questions: Within a PHC framework, how could the older women play a more prominent role as first-line practitioners in the home? Could they be afforded the vital role of preserving the plants used for healing purposes, just as the women in the Indian health care system have the role of ensuring the survival of the healing Tulasi plant in their homes (as they ensure the survival of their own children)? (45) How can the survival of IHK be prioritised for coming generations? (45) What this study ultimately asked was, what research was needed as a first attempt to understand IHK and to preserve its essential components?

### **2.3.5 The need to research IHK**

In the past, the limited research that was conducted into IHK focused on quantitative rather than qualitative studies, and was driven by pharmaceuticals in partnerships with Schools of Medicine who focused on trials of efficacy (RCTs). Very few studies focused on accessing and assessing the quality of indigenous health care (including the community public health-orientated research, such as the studies carried out by Katzellenbogen). (82)

It is against this backdrop that it is important to understand the prevailing perceptions about research on IHK in general (101,104,107), and IHK carried by older women in particular. (3) In the past, the war waged against indigenous people raged around territorial lands, waterways and oceans. (107) Increasingly, these contests shifted to the intellectual realm, to cultural practices, and to the terms under which indigenous knowledge systems could survive in modern times for the benefit of indigenous knowledge, that will ultimately benefit all peoples as indigenous knowledge encourages the protection of the nature and the earth that supplies us with means to produce food as well as medication. (7,8) The health-seeking behaviours of indigenous people, coupled with the need to deliver comprehensive health care has been a drawing force for researchers, who see this terrain as an important area for exploration. (5,6,103,104,108,109,110)

#### **2.3.5.1 Science and indigenous knowledge**

Three debates that have taken on distinct forms as a result of the modus operandi between science and indigenous knowledge, namely: opposition to the promotion of science as the

only valid body of knowledge; the rejection of science in favour of indigenous knowledge; and the misinterpretation of knowledge by the use of system-bound criteria.

Firstly, opposition to the promotion of science as the only valid body of knowledge has attracted many followers. In the past few centuries, progress in science in the Western world, has become the dominant global knowledge system and has often been accused of being narrow in focus and intolerant of other persuasions. If a conclusion cannot be supported by concrete, empirical evidence, if practice is not evidence-based, or if there is an inability to replicate results, then validity is in doubt. (43,16) Method is important and objective measurement is even more important and becomes the final arbiter. Systems of knowledge that do not subscribe to scientific methodology are afforded a lesser status and, if given any recognition at all, run the risk of being explained according to scientific principles. (7,8, 43,46) If it is not totally discounted as irrelevant, knowledge that may be called 'non-scientific' and use scientific methods to try and explain it to the extent that it is rendered meaningless because it is out of context with other components of scientific explanation. (72)

On the other extreme, the second debate revolves around the total rejection of science in favour of indigenous knowledge. Just as science has either ignored indigenous knowledge or reinterpreted it to fit in with scientific logic, indigenous people have in turn frequently dismissed science as an illegitimate knowledge base because it seems incapable of explaining spiritual phenomena or even recognising the existence of nature as something more than a scientifically-observable construct. Sometimes the rejection is simply based on the fact that science is associated with, and seen as 'a tool' of the coloniser. A more complex argument is that standard scientific method is based on analysis into smaller and smaller components, while indigenous knowledge places greater emphasis on the construction of models where multiple strands can be accommodated to make up an interacting whole. Understanding comes not so much from an appreciation of component parts, as from the synthesis into a complex whole - thus the underlying basis of each system is in conflict. (43,72,77,78)

Finally, misinterpretation of knowledge by the use of system-bound criteria does occur. Indigenous mistrust of science on the one hand, and scientific disregard for indigenous knowledge on the other, have a common tendency to evaluate each other based on their own system-bound and limited criteria. Science is one body of knowledge, faith is another; and indigenous knowledge is yet another. The tools of one cannot be used to analyse and understand the foundations of the other, or to draw conclusions about the different systems of knowledge. (45,72)

### **2.3.5.2 Exploring the interface**

Contesting the relative validity of science or indigenous knowledge is usually conducted on the basis that one is inherently more relevant than the other. Hardly ever does such a polarised debate generate wisdom and seldom does it lead to the generation of new knowledge or fresh insights. Instead positions become more entrenched as proponents defend their ideological positions. (45,72,77-78)

The literature review has shown how individuals seeking health care often achieve their own form of holistic health care by using both Western and indigenous health care. It is not unusual for scientists or indigenous peoples to live comfortably side-by-side with the contradictions of different bodies of knowledge. Many scientists subscribe to religious or spiritual beliefs. Likewise, many indigenous people use scientific principles and methods in everyday life while at the same time holding onto their indigenous values. (32) It has been shown that many traditional healers have adopted some Western methods to enhance their practices (57), and that some Western doctors recognise and acknowledge the healing qualities of IHK. Rather than contesting validities, each uses the interface between science and IHK as a source of inventiveness. They have access to both systems and use the insights and methods of one to enhance the other. (57) The focus shifts from proving the superiority of one system over another, to identifying opportunities for combining both. (45)

Whittaker (108) has argued for a social contract and a broad agreement about training which will produce health workers in all sectors of the health care field and educate them on the need to work collectively for the common good of their clients.

### **2.3.5.3 Researching the IHK carried by older Xhosa women**

There is an urgent need to research the IHK carried by older Xhosa women in particular because it is believed that this knowledge lies at the interface between the health care system and the home. (109) There are many reasons for the need to explore this knowledge. Firstly, most of the older women who are the carriers of this knowledge are illiterate. Hence, they are unable to document their indigenous knowledge for future generations. (60)

Secondly, in the past, IHK survived through word-of-mouth, by means of it being taught to the grandchildren who continued as the carriers of this knowledge. Nowadays, with the migration of younger people to cities this chain of information has been broken and the death of an older person means the loss of rich reservoirs of IHK. (27,60)

Thirdly, the researcher holds that there is a dire need for a model, based on IHK, to assist with the containment of minor health ailments within the home situation. However, before such a model can be implemented studies are needed to explore the following:

- a. What is the pharmacological reaction of some of the herbs used by older women to contain minor health ailments within the home situation?
- b. If dangerous substances/medicines are being used, these will need to be discouraged. In this context, knowledge, attitude, belief and practice (KABP) studies will need to be conducted regarding the use/disuse of these medications.
- c. As there are at least 11 different cultural practices in South Africa, it is assumed that the above studies would apply to indigenous health practices beyond the scope of the older Xhosa women. Hence, the need to explore the IHK across South Africa's diverse cultures.

Finally, there are five community-based concepts/principles that could be used to make PHC more effective, namely, social capital (34,110), the asset model (111), the concept of ubuntu (112), horizontal learning (113), and community participation and developing meaningful relationships with communities. (114) All these concepts/ principles are readily available in communities. There is a need first to research them in the context of how they are practised in communities, and then, once understood, to integrate their core principles into PHC programmes and into the curricula of the Faculties of Health Sciences in South African universities.

#### **2.3.5.4 Previous research on IHK**

Durie (46) conducted a study to understand health and illness, pitching the research at the interface between science and indigenous knowledge. Durie's (46) proposition was to demonstrate that indigenous knowledge cannot be verified by scientific criteria nor can science be adequately assessed according to the tenets of indigenous knowledge systems. Three case studies were used to demonstrate how the incorporation of indigenous beliefs into research protocols, health measurements and health perspectives, could enhance health research and the understanding of health and illness amongst the Maori of New Zealand. These case studies showed how Durie (46) bridged the gap between the two approaches.

In the first case study, Durie (46) included Maori researchers who advised on areas of methodology that could cause discomfort to the study participants. He also included food stuffs that were indigenous to the Maori. In respect of body fluids, ceremonies were conducted to render the laboratory 'safe for blood to be tested'. This effort to harmonise the two approaches made participants more willing to participate.

In the second case study regarding health measurements, Durie (46) took cognisance of the fact that for the Maori tribe wellness means more than the removal of a symptom. Instead they espouse a more holistic interpretation. Hence, in the health domains he included

biological, psychological, behavioural, spiritual, social and cultural domains. The last aspect for exploration in these domains was related to the results of intervention and it examined whether the person had become 'stronger as a Maori'. This was measured on a five-point Likert scale. Lastly, the person would be asked whether he or she felt 'valued and healthier from a spiritual point of view'.

For the third case study on the health perspectives of 400 Maori participants, a tool was developed that could capture the interaction of the Maori in relation to land, language and tribal gatherings. Health was measured according to participation in tribal activities and inclusion in family celebrations. These were then adopted as a proxy measure for 'Maoriness' and enabled a correlation to be made between spirituality, cultural affinity, material well-being, general health status or disability.

A similar study was done by Palafox (115) whereby health disparities were explored between the indigenous peoples of the USA Associated Pacific Islands and compared to that of any population in the USA. The aim was to improve health outcomes in the diverse population. According to Palafox (115), it was not sufficient to train more indigenous Pacific Islanders to do more western-style research. It was concluded that culturally competent cross-cultural research with the indigenous peoples of the Pacific Islands requires an understanding and application of their indigenous knowledge system's paradigms of health, knowledge, science and research.

The next two studies are related to perceptions regarding the health-seeking behaviour and type of health provider sought. Broad and Allison 2002 (116) published a paper on the nurse practitioners and traditional healers: An alliance of mutual respect in the art and science of health practices, whereby 30 residents were interviewed regarding the type of health provider sought and perceptions regarding each provider. Seventy per cent (70%) of residents used both traditional and Western medicine simultaneously and were satisfied with the care they got from both. Western care was sought predominantly for acute conditions such as acute respiratory problems, infections, allergies, high blood pressure and diabetes. Traditional care was sought for chronic illnesses such as back and neck ache. This study coincides with Eisenberg's (35) study on alternative therapies in which she reported that in the USA since 1990, there has been an increase in the use of alternative therapies, from 33% in 1990 to 42% in 1997, with alternative therapies in 1992 netting 12.2 billion dollars. In Eisenberg's (35) study, the main interventions sought were relaxation techniques, herbal medicines, massage, self-prayer and chiropractics (amongst others).

Cook (16) explored the use of traditional Mi`kmaq medicine amongst patients at a First Nations community health centre and their attitudes towards both Mi`kmaq and Western medicine. Fourteen (14) men and 86 women completed a questionnaire regarding the use of traditional Mi`kmaq medicine. Sixty-six percent (66%) had used the traditional Mi`kmaq medicine and 92% of them had not discussed this with their physicians; 24.3% had used it as first-line treatment, and 31.8% believed the use of traditional Mi`kmaq medicine was overall better than Western medicine. Even amongst those who had used it, 5.9% believed it was better than Western medicine. It is important to note that with the traditional Mi`kmaq the use of traditional medicine increased with age. These results coincide with results of the studies of both Broadand Allison (116) and Eisenberg (35) as well as with those of Mlenzana (19), who conducted a study in CHCs in Khayalitsha.

Poudyal et al (117) evaluated a Western training model for traditional healers in Nepal. They used semi-structured interviews to compare 48 trainees with 30 randomly selected untrained traditional healers, one year after their training was completed. They asked them about their knowledge of the causes, prevention and treatment of common illnesses and HIV and AIDS, and their relationship with government health workers in that area. Nine government health workers were interviewed about their perceptions of traditional healers. The trained traditional healers had a better knowledge of allopathic medicine, practised modern treatment using first aid kits and were more likely to refer patients to government health workers. Government health workers regretted that they had behaved rudely towards patients who visited them after first consulting traditional healers. They were more willing to treat patients referred by traditional healers and agreed that regular meetings should happen between them and traditional healers. However, they expected other external agents to facilitate the meetings. There was also no indication that they would refer their patients to traditional healers. This study has similar findings to studies done in South Africa by De Villiers and Ledwaba (118); Bland et al (83); and Mlenzana (19).

Peu et al (119), in their study on the attitude of community health nurses towards the integration of traditional healers in PHC facilities in North West Province in South Africa found that community health nurses had a different attitude and opinion towards traditional healers than those based in health institutions. They believed that the contribution of traditional healers to the health of the indigenous community cannot be ignored as many patients have a dualistic approach to illness. Traditional healers are respected by communities and many African families believe that illness is caused by witchcraft and dissatisfaction with ancestors. For these patients, it is only logical to consult a traditional healer. They mentioned the conditions that drive people to consult traditional healers as

marital problems, work, children, family, love and poverty. The community health nurses who were interviewed wanted traditional healers to be integrated within the PHC system in South Africa. This perception is in line with the study by De Villiers and Ledwaba (118) on traditional healers and paediatric care. They asserted that the integration of traditional healers with biomedical care could only result in mutual learning, which would lead to more comprehensive care of the patient.

Perceptions exist that health professionals are more reluctant to develop a meaningful partnership with traditional healers, whereas a host of studies have shown the willingness of traditional healers to work with health professionals. In a short report entitled, 'Traditional healers fight for recognition in South Africa's AIDS crisis' (2005), the author, Watson (120) documented how traditional healers marched in frustration to an organisation supporting HIV and AIDS clients, demanding recognition for the work they do with HIV/AIDS patients, which they stated was being downplayed by the South African pharmaceutical companies and the media. According to Watson's report (120), 70% of South Africans consult traditional healers; and traditional healers make up 200 000 of the health professionals. Hence, it is important to investigate methods of establishing an alliance with them (120).

The final studies reviewed here are related to data analysis and methodology issues.

Vandebroek et al (121) studied the use of medicinal plants and pharmaceuticals by indigenous communities in Bolivia and the Amazon. They measured how distance from health facilities influenced the use of IHK. They found that increased distance from the health facility was directly proportional to increased usage of medicinal plants. The communities that had the greatest knowledge of medicinal plants were more likely to be farthest from the village where a medical doctor and PHC were available.

Although this doctoral study focuses on exploring the indigenous knowledge carried by older Xhosa women in the home situation with a special focus on IHK, there are other studies that have concentrated on women as healers. One such study is that of Struthers (46) who purposefully selected six Obinjwa women healers to share their experiences of being traditional healers. Struthers (46) used storytelling as a method for these women to give an account of their lives, backgrounds and traditional healing practices.

### **2.3.6 Summary of Section 2.3**

This section has highlighted that there is a dearth of literature examining South African IHK, and that the literature that is available mainly focuses on dangerous practices. Section 2.3 exposed the challenges faced by missionaries, missionary doctors and missionary educators to achieve compliance with Western medicine amongst the Xhosa population. It expanded on

the lack of understanding of the Xhosa culture by Western medicine. Since the missionaries were orthodox Christians, it was difficult for them to accept the link between health, ancestors and the dead. Berg's (49) study outlined Xhosa psychiatric management strategies and the use of rituals to demonstrate the integration of ancestors within the psychological make-up of the Xhosa individual.

The section also gave an account of IHK around the world. Their common main aim is to restore balance. IHK does not divorce illness from the health continuum. The section concluded with the need to research IHK so that it could be more fully understood by the South African health system.

## **2.4 INTRODUCTION TO SOUTH AFRICAN PUBLIC AND PRIMARY HEALTH CARE (PHC) DELIVERY**

The older Xhosa women in the introduction chapter of this thesis expressed concern about being chastised by health professionals, for using home remedies prior to visiting the PHC centres in Khayelitsha in Cape Town. This is a common anxiety heard by many researchers, who are calling for health professionals at the primary level of care to firstly, try to understand what approaches and medicines people use at home when they are faced with the illness of a family member; secondly, to learn about the good as well as the dangerous aspects of these approaches; and finally to be more proactive in trying to integrate the two health systems.

This section introduces the public health care delivery and PHC systems in post-apartheid South Africa. It outlines the challenges faced by the ANC's 'Health for All by 2000' agenda; and it reviews the six strategies that might bring hope post-Alma Ata, as well as health care changes in South Africa. The section concludes with the implications of these six approaches for PHC.

### **2.4.1 South Africa's health system post-apartheid**

When the ANC-led democratic government came to power in 1994, it developed many policies that were aimed at bringing about change in the lives of the South African population, especially for those living in under-served, peri-urban and rural environments. It used the Reconstruction and Development Programme (RDP) as the yardstick for broader basic government policy to measure whether its policies would respond to, and have an impact on, the development of the South African people. (18, 122) The RDP defined a whole series of policies, projects, programmes and priorities for the government to achieve over a period of five years, which were geared to the development of the people. Health policies were amongst those policies that required the new government's immediate attention.

Amongst the most fundamental improvements South Africa's first democratic government sought which related to the area of health, were an increase in basic infrastructure (water, housing and sanitation) and the implementation of poverty alleviation strategies. (52,122-125) The major aim of the 1994 Health Plan was a health care delivery system based on a decentralised primary health district system. The plan was informed and guided by the principles of the United Nation's Alma Ata Declaration and its 'Health for All by 2000' campaign. (121,123,53,126-129) There was a shift of emphasis and funding from the large tertiary hospitals to PHC clinics and CHCs. The new era saw the upgrading and building of new clinics, as well as the early development of the district health system. Along with these structural shifts, White Papers and policies were developed which provided an overarching view of PHC as an integral part of the overall development of a society that concentrates on 'putting the last first'. (81) PHC was perceived to be the key to attaining an acceptable level of health by all, as it would help people contribute to their own physical, social and economic development.

#### **2.4.2 The challenges of the 'Health for All by 2000' agenda**

Much as the new government's health agenda was geared towards shifting both human and financial resources from the large incumbent tertiary institutions to the district level, there remained no clear plan regarding the percentage of shifts, or any operational plan for all layers of the health care delivery system, including primary, secondary and tertiary health care. It was not clear how these sectors would relate to each other or to referral systems. (122) This lack of an overall driving health plan had devastating results at the crucial delivery end point of PHC – at the CHC level – and for the communities themselves.

As described in Chapter 1, the situation at the CHC level was difficult due to a shortage of human resources, resource allocation problems, and the type of model used to deliver PHC. Overcrowding at these facilities was the order of the day. (3,15-19) This situation was partly the result of not having an overall plan to drive health services in South Africa, including PHC, which included, amongst other things, the analysis and synthesis of the fourth element of the Alma Ata Declaration of 1978: that the people have the right and duty to participate individually and collectively in the planning and implementation of their health care. (81:21) The new health care agenda did not discuss how communities would work together with government to develop PHC. Issues such as client accountability and responsibility, the client-health worker relationship, measures to address staff fatigue and the sustainability of services, could have been discussed in community health forums; and roles and responsibilities of each stakeholder could have been delineated.

According to Werner and Saunders (81), PHC is a holistic strategy that recognises that the majority of illnesses are a manifestation of community-based problems that lie festering because they are not attended to at home and at community level. At the core of the social determinants is poverty which is a global illness and affects both low and high income countries. Hence, PHC emphasises a community developmental approach that is participatory and intersectoral. (81) The situation of CHC's being overcrowded is a reflection of the ill-health that is being played out at the home and community level. (3,18,22) This has never been so clearly portrayed as in Mondli Makhanya's (130:18) editorial comment in the Sunday Times (30 December 2007). He comments that in the new South Africa he has seen many positive changes, as well as many new problems that have not been addressed. The challenge facing health care professionals in PHC settings is overcrowding and patients who have attempted to self-medicate before coming to the clinic, mainly because they had limited access to public health care as there is a general belief from the health professionals that they have made the condition worse. (18,19) The situation at present appears to be as follows:

- There is a public health care system that absorbs most of the budget but fails to address inequities in health. The public health care system is predominantly used by the poor who remain ill as inequities persist.
- Gessler (18) and Mlenzana (19) describe the type of services offered in these centres. Fragmentation is the order of the day with little attempt at an integrated, interdisciplinary approach which links PHC to health promotion and prevention about disease. (11,12) For example, if a doctor is too busy to educate a patient during a consultation, he or she does not refer the patient to another level of worker for this purpose.
- There is a general lack of research and research evidence on PHC models that have worked, or the moving of evidence to action. In Africa specifically, much of the research has been concentrated in English-speaking countries. Furthermore, the research arena is marked by competition amongst academics for research funds. Interdisciplinary research has not yet surfaced.
- In South Africa there are unspent budgets due to poor planning and a lack of human resources. This exacerbates health inequities and inadequate service delivery. (19)

The quest to address inequities and improve health has focused on gathering information about what works, but from a deficit point of view. That is, there is a tendency to focus on identifying the problems and needs of populations who require professional resources, rather than on the assets that already exist within these populations, that could be utilised more effectively. This deficit point of view creates a high level of dependency on hospital and

welfare services. (112) It leads to policy development that focuses on the failure of individuals and local communities to avoid disease, rather than on the potential to create and sustain health and ongoing development.

Despite calls for all health policies to address equity issues, many government policies are implemented without adequate attention to their impact on health or on health inequities. When the principles of equity and social justice are lacking in a society, social inequities result. These end up being expressed as differences in health amongst individuals. (131) In order for the differences to be seen as injustices that need to be righted, a value judgment must be made. (132) Targeting poverty alone does not result in resolving inequities and could even result in deepening and reproducing inequities; (133) Likewise, addressing health needs only in a medicalised fashion merely deepens health problems and the underlying inequities. For example, a patient who waits the whole day at a CHC for a panado while children are alone at home with no one to give them proper guidance, creates the potential for other health problems to develop during this time.

Policies need to be long term. They require intersectional collaboration and continued resources for the goals of sustainability to be achieved. (133-135) There is little empirical evidence about the effectiveness of current health strategies, and the available evidence stops short of explaining how actions might work for different population groups in different contexts. This is precisely what Alma Ata failed to do. (133) Current health approaches, based on the deficit model, have stimulated a desire for instant gratification in communities. While this model is essential for evaluating the gravity of a specific health problem, there also needs to be recognition that health is created, and that, as people evolve, they continuously define their own health. (111,135)

### **2.4.3 Hope after Alma Ata and health care changes in South Africa**

The Alma Ata Declaration of 1978 and the health changes in South Africa post-1994, generated an expectation of better health services. Alma Ata recognised that health improvements would not occur by just developing more health services or by imposing public health solutions from the top down. (106,133) Alma Ata heralded a shift in power from providers of health services to the consumers of those health services and the wider community. (134) However, how the community was currently managing their health was not addressed. (3,18) In areas such as Khayelitsha, where the availability of health care services has improved, has not automatically meant that people have been able to access these services as there is a perception that there was lack of planning for the implementation of the new services in this area. (3,17,19)

It was with this conundrum in mind, that global health meetings and activities, such as the Ottawa Charter of 1986, were born. (133) Again, those in health power were reminded of the need for sustainable development and urged to undertake social action at a community level, with people who are most affected being the driving force of development. The Ottawa Charter of 1986 emphasised five dimensions of health:

1. building public health policy;
2. creating supportive environments;
3. strengthening community action;
4. developing personal skills; and
5. re-orientating health services. (133-135)

In addition, with the new millennium the world was changing dramatically and these changes included the determinants of health. The Internet, the human genome, climate change, terrorism, economic and geopolitical change, all had a direct impact on people, money, products and services globally, as well as on the persistent Third World debt. (135) Together with basic health inequities globally, and the accompanying challenges, there was also the challenge of keeping up with these rapid global changes. Those representing the health agenda of the poor found they were required to develop both local and international partnerships and alliances. They had to take cognizance of global finance and information systems, including trade. In addition, the need to answer the question concerning what really creates health in individuals and communities remained. According to Ridde, Guichard and Hueto (110:12):

Health is created in the context of everyday life where people live, love, work and play. Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health. Health is not only a state of well-being as the WHO definition of 1948 proposes but a reserve for living - an input.

From Alma Ata (1978), to the Ottawa Charter (1986), to the Bangkok Charter (2005), there is agreement that a reduction in social inequity is the key to tackling health problems. Programmes that do not focus on reducing social inequalities are detrimental to health. This was called an 'inverse equity hypothesis', whereby new interventions tended to increase inequalities, since they primarily benefited those whose state of health is already good. (110) For example, in a health facility where doctors cannot speak the indigenous languages of the specific community, patients who cannot speak English will tend to shy away, and mainly fluent patients will use that facility with ease. To reverse inequities in health, health promotion programmes need to assert themselves outside the population health domain into the domain of life so that health does indeed become 'a reserve for living'. (111)

### **2.4.3.1 Community-based models - hope for Alma Ata and Primary Health Care (PHC)**

Some schools of thought see community-based models as having the potential to implement the agenda of Alma Ata and PHC. Said models, first and foremost, draw on what is already available within a community. Five approaches/models that are perceived as having had an impact on the existing *modus operandi* regarding PHC and that could provide a way forward are discussed below. These include: the social capital model; the asset model; horizontal learning/recognition of prior knowledge; relationships in development; community participation and model of disease prevention and health promotion.

The social capital school of thought: In this approach, the interconnectedness of people in a community creates health - through their sharing and laughter. Sharing and laughter are the fruits of the people who contribute towards health. (112,124)

The asset model: This approach uses the assets embedded within communities to determine health. In this model, people jointly identify problems, as well as the assets that exist to solve these. In this way the esteem of individuals and communities is stimulated, and this leads to reduced dependency on professional health services.

The horizontal learning approach with recognition of prior knowledge: According to this approach if PHC programmes within the African region are to be successful, they must be implemented by utilising some essential African cultural principles, such as *ubuntu*. The community is the social interface where personal health and abilities, as well as illnesses and disabilities, are declared and are most apparent. Thus, the community becomes the point where health interventions can most effectively be directed and applied. Decentralisation of health services to the community and the integration of those members who are defined as ill and disabled into society, demands closer interaction with cultural factors and values.

Relationships in development: The fourth approach holds that development happens within relationships. We live, learn and develop within three different types of experience and relationships: relationship with the self, interpersonal relationships with the people around us; and external relationships with the rest of the world. Power is held in relationships, whether it is the struggle we have with ourselves to claim our inner power; the power we have over others; the power we hold with others; or the power that the state wields in relation to its citizens. Without relationships, power means little; it has no force for good or bad. If we want to shift power, we have to shift relationships. It is within these three levels of relationships that people are deemed free or not. Elders in communities have vertical

relationships with more junior community members/learners. The elder-learner relationship is usually intimate and complex. As members of the same community, both elders and learners are 'insiders' and share many aspects of a peer relationship, but the elders in particular also bring with them story and history, local knowledge and wisdom, culture and tradition (both useful and not). When these are shared in the context of the elder-learner relationship, they come not from outside, but from deep within the community, from out of the past, revealing what already belongs to the community, its heritage and its identity. (35,111,112, 114,115)

Community participation: This is said to occur through the development of meaningful partnerships with communities. This is another key PHC concept and principle. Boyce and Lysack (107) maintain that the origins of the modern notion of 'community' are traced to the European social philosophers of the late eighteenth century. These scholars noted that the growth of capitalism, industrialism and urbanisation altered the relationship between humans and society in a fundamental way. The result was a loss of interdependence, which the four previous models have alluded to. (108,111,112,114,115) Since then, sociological research has attempted to categorise communities empirically, but with limited success. Currently, the term 'community' has two general meanings: firstly, it refers to the social ideals of solidarity, sharing and consensus; secondly, it relates to the actual grouping of people. In the first instance, this can facilitate an incentive for individuals to assume a shared set of interests since physical proximity increases the likelihood of social interaction.

Disease prevention and health promotion by Katzenellenbogen, Joubert & Karim (82): Many public health care practitioners are of the opinion that the world economy, and the natural resources that are presently available simply cannot cope with the curative and rehabilitative sides of an approach that appear to be demanded by the prevalence of disease and impairments. (82) They perceive that prevention measures of all kinds in addressing the impairment debate are the most cost-effective steps that public and private sectors could ever take and implement in order to alleviate and cope with impairments and disease, worldwide. (131-135) All these researchers recognise that not all impairments and disease are preventable, but by starting to develop programmes that target prevention, early detection, prompt and proper intervention, community-based rehabilitation and social integration public health care providers will be addressing some of the challenges of revolving door syndrome that appear to characterize the public health services of

today. Health professionals appear to be content in minding the patients that come through the gates of health services without trying to gain an understanding of the most important attributes of a public health care provider - the asking of whom, where, how and how long. It is in this regard that Katzellenbogen et al (82) published the poem below to demonstrate how by neglecting disease prevention and health promotion public health care service providers face a challenging time:

It was a dangerous cliff as they freely confessed  
 Though the walk near the crest was so pleasant  
 But over its terrible edge there had slipped a Duke and full many a peasant  
 So people said something would have to be done  
 But their projects did not tally  
 Some said, put a fence around the edge  
 Some an ambulance in the valley. (82:13)

They (82) further developed a model of how public health care providers could approach the area of disease prevention and health promotion. Four stages are included in this approach and below in table 2.7 is Katzenellenbogen, Joubert & Karim's model of levels of prevention and health promotion:

**Table 2.7: Levels of prevention and health promotion strategies (82)**

<b>PRIMODIAL</b>	<b>PRIMARY PREVENTION</b>	<b>SECONDARY PREVENTION</b>	<b>TERTIARY PREVENTION</b>
Disease prevention and health promotion: <ul style="list-style-type: none"> <li>• Target life style factors with high risks</li> <li>• Target groups where risks are not yet high (health promotion)</li> </ul>	Averts occurrence of disease: <ul style="list-style-type: none"> <li>• Encompasses health promotion and specific protection</li> <li>• Controls environmental causes of disease, occupational hazards</li> <li>• Immunization</li> <li>• Prophylactic medication</li> </ul>	Early detection , screening programs: <ul style="list-style-type: none"> <li>• Early diagnosis + Prompt Rx slows/controls progression:</li> <li>• Intervention programmes</li> <li>• Strong referral systems</li> <li>• Public education</li> </ul>	Treatment of disease and rehabilitation: <ul style="list-style-type: none"> <li>• Treatment + Rehabilitation to optimal function, prevent - minimize secondary impairment</li> <li>• Occupational training</li> <li>• Re-integration back to community</li> </ul>

The four prevention strategies mentioned above in the table stressed the following:

- Coordinated referral system
- Inclusion of training programmes

- Public education and awareness raising
- Key performance indicators that can be used to monitor progress

#### **2.4.3.2 Implications of the six approaches for this study**

This study is embedded in and influenced by the six schools of thought discussed above. When the researcher consulted with the community health forums about developing a community-based solution to the problem of overcrowding at CHCs, it became apparent that the forums were already utilising the core concepts and practices in these schools of thought. The previous investment in relationships and social capital within this community was already having a spin-off, so that for example, when the CHCs encountered a problem, they did not have to solve it alone, but could use the community's problem-solving skills as an asset. (3,19)

The forums acknowledged the issue of health-seeking behaviour of community members as a complex one. A variety of reasons were given for clients visiting the CHCs for minor ailments instead of managing these at home. However, the forums argued that if clients perceived the prior IHK held by older women and that is lying dormant in their community, as an asset, they would use this knowledge first before visiting and CHC, thus relieving the problem of overcrowding in CHCs.

The utilisation of the principles that underpin horizontal learning, if used effectively, could raise awareness about the value of IHK and a partnership could develop between the CHCs and the communities. The older women would play a pivotal role as first-line practitioners in the home, thereby building a bridge and a channel of recovery between the home and the institutionally-based biomedical care for the ill person. Since the older people are seen as trusted members of community who carry past experience, they could be a bridge to transfer their knowledge to the community, and in this way create a healthier community with improved health-seeking behaviours. However, as Boyce and Lysack (107) remind us, there are important power issues at work in relationships; and in this study it was important to investigate the potential of an equal and co-operative power relationship between the doctor-driven medical institution and the home, which is guided by individuals (older women) who are seeking to revive IHK. Katzenellenbogen, Joubert and Karim (82) put emphasis on disease prevention and health promotion as one of the ways that could turn the tide in public health care services.

#### **2.4.4 The role that could be played by older Xhosa women in primary health care**

The need to recognise and integrate the IHK of older women into the first level of PHC within a modern health dispensation must be recognised. Scott and Wenger (37) have shown that

women's accounts of their health are structured around age and gender. They argue that women can become more powerful and autonomous in old age, and that despite their age, they take on new roles and duties which are conducted in a caring, loving way and with expertise gained years of understanding, knowledge and experience. (92)

#### **2.4.4.1 Knowledge held by olderwomen for caring and healing**

Boneham and Sixsmith (38) maintain that the voices of older women are rarely heard in debates about health. Consequently, there is very little research that explores the ways in which older women contribute to the health economy and social capital of their communities. This contribution is neither researched nor documented. (35,38)

According to Clough (40), the talents of women have been carefully integrated into their day-to-day activities. So much so, that these talents have been classified and simplified as part and parcel of 'the role' woman are seen to fulfil in society, for example, terms such as labour of love, are commonly and loosely used. In South Africa, with the AIDS epidemic, the older people, and specifically the women, have become a pillar of strength to AIDS orphans. (43)

In order to value the contribution made by older women they need to be firstly recognised and valued as lay health experts who are regularly consulted by family and friends (136); and secondly, there needs to be a greater understanding and the documentation of the knowledge that these women carry .(3) In addition, the negative assumptions and perceptions about age, gender and ill health that are carried by mainstream society need to be challenged. Mainstream medicine for example tends to label the physiological changes of menopause as being deviant and in need of intervention; and reinforces the societal assumption that older women are weaker than men and more dependent. (38) Alternative interpretations which stress that these physiological experiences are a normal part of development, need to gain currency. (38)

Boneham and Sixsmith (38) suggest that women's dual roles as caregivers and receivers, especially those caring for disabled persons, have been underestimated. They claim that a gendered evaluation of health and health care is more likely to position older women in a more positive light and construct older women as active agents in health matters, especially concerning their family. The role that older women take on in fostering a spirit of belonging, participation and identification in the local community needs to be claimed, as well as their role in promoting empowerment and change. Data on social participation indicate that older women are more active than older men in terms of voluntary work, group membership and attendance of social events. (37) In Zonke's (3) study of the IHK carried by older people, male participants were less vocal than their female counterparts during FGDs. The main

qualitative contributors were older women even though males formed 48% of the study sample.

Bell (137) supports this concept of the empowering role of women, when describing the Australian aboriginal older women who are the active ritual leaders and the repositories of religious knowledge. They have reared children - not necessarily their own - into adulthood and have acquired the necessary knowledge befitting the status of ritual leaders. Bell (137) explains that in rituals these women emphasise their roles as nurturers of people, land and relationships. Through their *Walwuyu* (land-based ceremonies), they nurture; through their health and curing rituals, they resolve conflicts and restore social harmony; and through *Yilpinji* (the love rituals), they manage emotions. Thus, their major responsibility as ritual leaders is in the areas of love, land and health. As part of their nurturing nature they see their role as being the custodians of 'the growing up' of people and land; as well as maintaining the harmonious relationship between people and the land. They use certain rituals to affirm their commitment and intention to 'grow up' country and kin. (137)

Bell (137) further explains that although women allow discussion of the structure of their ceremonies, they will not permit the details of songs, certain designs and ritual objects, to be made public. Occasionally, this has meant that women appear to be ritually impoverished, but they find this more acceptable than compromising their secrets. This relationship between land, people and rituals is similar to that of women from the North and Western parts of the world towards their families and Earth mother before their healing practices were taken away during the systemic masculinisation and industrialisation of their livelihoods and the institutionalisation of their health vocation. (39)

Struthers (48) calls for the increased awareness of health care providers who practise the ancient art of traditional, culture-specific healing and health care in their communities. She explains that for a long time in the USA and Canada, it was against the law to practise traditional healing, but despite this, indigenous healing practices continued to thrive. (71,73) The challenge now rests with how to integrate this knowledge into the highly-developed biomedical care model. Previous attempts show that practitioners of the biomedical model are resistant to integration, claiming that indigenous healing practices are generally dangerous; and prefer to influence the traditional side to rather change and embrace biomedicine. However, in specific countries, these attempts have unveiled what could be interpreted as positive results. For example, Ho`gberg (75) states that in the Netherlands, Norway and Sweden, low maternal mortality rates were reported by the early nineteenth century and were believed to be the result of an extensive collaboration between physicians and highly competitive, locally available midwives, especially in the rural areas. However,

over time, local birth attendants were phased out as biomedically trained midwives were introduced.

Hinojosa in 2003 (76) shares a similar concern regarding the approach used by Guatemalan health authorities who consistently tried to refashion the vocational framework of Mayan midwifery in accordance with Western medical principles. The on-going privileging of biomedical knowledge created an environment which favoured health personnel and enabled them to extend their influence through the local Mayan midwives into the community. For example, Mayan traditional birth attendants encouraged kneeling or squatting during delivery. However, these positions were frowned upon by biomedical midwives as they argued that with these positions the child descends with too much force and the afterbirth can become stuck within the mother or be expelled onto the ground. Instead they encouraged the lithotomic position (lying flat on back with knees raised) or a semi-reclining position. Hinojosa challenges these positions by quoting Jordan 1993 who reviewed the lithotomic position and concluded that it was dangerous because: (a) it decreases the size of the pelvic outlet; (b) it negatively affects the mother's pulmonary ventilation, blood pressure and cardiac return, thereby lowering oxygenation to the foetus; and (c) the position as such lends itself to the mother pushing too hard for too long and thereby becoming exhausted before accomplishing what is required, namely, the birth of the baby, which is sometimes accomplished by external measures such as forceps deliveries or episiotomies. This study clearly shows how difficult the clash of cultures is for those caught in the crossfire of competency beliefs, values and technologies as each approach wants to prove that it is the most effective one.

#### **2.4.4.2 Challenges facing traditional middle generation women**

The younger women in rural areas face many challenges, as modern health systems distance them from the traditional older women. (138) Not only do African women have to cope with problems of poverty and the transition from the rural to urban environment, they also have to deal with levels of frustration, mistrust, anger and lost identities resulting from systems such as apartheid, as they too have to deal with their husbands and their families levels of frustration. (139). Using childbirth as an example, Sheila Kitzinger in Chalmers (139) expresses the issue as follows: "Childbirth is never completely natural" – it is really a cultural artifact. In the processes and events of pregnancy and labour, we witness the shaping of nature into a social purpose. It is women who are at the centre of this cultural maze. Despite the contrasting views of traditional and Western medicine about health and illness, it might have been hoped that women giving birth could retain the community's support for holistic, traditional birthing practices, while enjoying the greater physical safety offered by Western

medicine. Unfortunately, hope rarely reflects reality. More often than not, these women have lost the former, without reaping the benefits of the later; and “rather than experiencing both cultures simultaneously, these women appear to be experiencing neither culture fully”. (139:116)

In the traditional birthing process, information and probably also some misinformation was conveyed to young mothers by older women. However, the perception of traditional birth attendants is that their methods worked. At least the preparation was congruent with women’s birth experience. (139) For example, one 78 year old, traditional birth attendant is quoted as saying that she has been delivering babies in Belize since the age of 13 years, and has never lost a mother. She does not use pitocin or merthergine or forceps or surgical techniques, but claims that her skills are intuitive. (140) Lately preparations for pregnancy and birth, whether African or Western, appear not to be meeting the needs of today’s women adequately. (139,140) When we compare traditional birthing practices with those practised in modern-day hospitals, it is the central concept of holism that appears most threatened. As debates rage between traditional and Western medicine about birthing techniques, it is only recently that the emotional aspects of birthing have come to the fore, and even less acknowledged are the spiritual needs of women. With a closer comparison of the two birthing places (African birth customs in traditional and urban settings), there is a growing awareness of the gnawing fragmentation in childbirth today. (140)

Some Western-trained practitioners serving in Belize have come to realise that a mix of traditional and professional care brings maximum results. (140) Bland (141) supports this notion by saying that mothers who are concerned about their infant’s welfare should not be afraid to approach health professionals because they fear being chastised for what they have done or not done. (3,18,19) Instead they should be encouraged to seek help from health professionals who empathise with their concerns and who do not criticise them, who give clear and consistent explanations regarding their infants, and who provide reassurance about perceived difficulties that do not require medical help. (138)

#### **2.4.4.3 Clinical nurse practitioners (CNP) and primary health care in South Africa**

The role of the clinical nurse practitioner in South Africa is to take the patient’s history and to do basic screening regarding whether the patient should be seen by themselves or a doctor and to manage minor health problems. (16,19) Since 1970, due to the shortage of doctors at the primary level of health care in South Africa, more and more medical responsibility has been shifted from the doctor to clinical nurse practitioner (CNPs). Mash (16) explains that South Africa has been unable to train doctors that are suitable for South African rural health needs, but has also not been able to carry the economic burden of over-skilled and

inappropriately trained doctors to provide basic care. It appears that there is also unwillingness on the part of many doctors to work in the areas of most need. (16) Hence, the idea was that the CNP should alleviate the doctor's workload by seeing a reasonable number of patients and by attending to minor ailments, leaving doctors to attend to more complicated cases. The CNP was to utilise his/her nursing skills to educate patients presenting with chronic illnesses. (3,16,19)

According to Mlenzana's (19) study, these CNPs are older women and can be compared to the Australian aboriginal women who practise their traditional dances and dreaming for healing. (137) They can also be compared to the people of Belize who quote Miss H's methods of assisting women to give birth, in which the CNPs act as mini-doctors at the primary level of care. (140) There might also be CNPs who are mothers and grandmothers in their own homes. Mlenzana's (19) study reveals how, during interaction, the predominantly women patients are reluctant to expose the care that they give in their homes, as they fear being chastised in CHCs by CNPs who are also mainly women, and who are usually their first point of contact in these CHCs.

Mash (16) maintains that the role of the CNP will continue to increase and come into a sharper focus in a 'nurse-driven' district health system, as the South African government attempts to implement its PHC policies. (16,19) They could well come to be perceived as 'mini-doctors'. (16,19) However, many questions remain, such as: What skills will be sharpened, as CNPs are schooled to become mini-doctors? Will these be skills that continue to distance them from other women clients? Will these women allow themselves to be used as instruments to continuously sharpen the isolation of traditional women healers *at this primary level of health care* and assist in the development of new, primarily male-dominated, institutions at this level? Kanter (142) explains how outsiders (newcomers or people who are not part of the situation) behave when they see themselves as 'tokens'; and how they role-play and mirror-image those whom they believe to hold the power that could make them one of the 'desirables' (insiders) in the organisation.

Mashile (138) comments on women's capability to juggle several tasks, but she also challenges this notion. To her, this skill is practised to its fullest when women are supported. Clough (40) maintains that pregnancy, giving birth, raising children, nurturing and caring, as well as reflection, are all part of being a woman and part of healing. The medical model has erased and repressed these features from the biomedically-trained CNP. (3,19,40) Through dialogue and discussion these features can be emancipated and again brought out into conscious awareness.

### **2.4.5 Summary of Section 2.4**

This section has covered the political health changes that occurred as a result of the ANC-led democratic government. It highlighted the hope these changes raised for the people of South Africa, especially those from disadvantaged communities who in the past struggled to obtain equitable and accessible health services. The section highlighted the challenges faced by the ANC government to achieve the lofty goal of 'Health for all by 2000', and how equitable and accessible health services have kept eluding the disadvantaged majority. Five strategies (the social capital; the asset model; horizontal learning; relationships in development, community participation and health promotion; and disease prevention strategy) that could improve the modus operandi of PHC were discussed, including how these strategies could be integrated into the South African health system. The section ended with a discussion of CNPs and their need for support.

### **2.5 Integrating IHK into the curricula of Health Sciences faculties**

This section examines the importance of integrating IHK carried by the older Xhosa women into the curricula of South African Health Sciences faculties. It presents a brief overview of the status of medical training in the previous political dispensation of South Africa and how the type of knowledge taught at these institutions ignored any prior knowledge of healing held by the majority of black South Africans. Instead medical education opted to import Eurocentric health knowledge. (110,115,143,144)

#### **2.5.1 Proposal for a Health Sciences curriculum based on a social contract**

There are eight Health Science faculties spread throughout South Africa. Since 1994 all have, to a greater or lesser extent, been engaged in curricula reform, and have attempted to ensure that their curricula reflect the principles and philosophies of PHC - the main vehicle for health care delivery in South Africa. These changes have brought about three radical shifts in these institutions: inclusion of community-based education; a focus on PHC; and the creation of integrated Health Sciences faculties (rather than Faculties of Medicine).

With the need to include community-based education, medical students were shifted from a solely institutionally-based medical curriculum to a mixed-mode one, in which they were expected to spend a sizeable amount of time doing community-based clinical work, especially in disadvantaged areas. Mji and Cilliers and Swarts, 2006 (145) There was also a shift in focus from a curative care-driven curriculum with specialities such as general and orthopaedic surgery, obstetrics, psychiatry and anaesthesiology and nursing, towards a curriculum that prioritised and revitalised public health and PHC, family medicine and rehabilitation. An attempt was made to prioritise professions such as occupational therapy,

physiotherapy, speech therapy and human nutrition, and to link with professions such as social work, psychology, education, and disability and rehabilitation studies.

The last shift was towards a change of name for medical schools from Faculties of Medicine to Health Sciences, with the aim of developing an integrated learning platform, and shifting from the professional-specific approach towards a client-centred approach and to team work. This brought about an awareness that the training of health professionals should be orientated around the complexities of health care and the realisation that there are no easy solutions, in the real world.

The first priority was to produce highly-skilled health professionals who were capable of addressing the many pressing health needs of South Africa. As pointed out in the White Paper - Transformation of the Health System (56) - the majority of South Africa's population has inadequate access to basic services including health, clean water and basic sanitation. Estimates are that the infant mortality rate (IMR), the under-five mortality rate (U5MR) and the maternal mortality rate (MMR) are much higher than what might be expected of a country with South Africa's level of income. Changes announced in some provinces regarding the structure of health care, such as in the Western Cape, implied that there would be radical changes in the infrastructure available for student education and training. (145) There was a general commitment in the Health Science curricula to respond to the health needs of all South Africans. The greatest challenge now is to ensure that there is greater demographic representation of students in the Health Sciences Faculties, to more accurately reflect the demographics of South Africa.

The Health Sciences Faculties are already on the road towards reform. Most have adopted the PHC approach together with such progressive methodologies to curricular reform as: (a) community-based education (CBE) (145); (b) problem-based learning; (c) community-based rehabilitation; and (d) interdisciplinary teaching and learning, besides other curriculum development changes. However, despite this curriculum reform, there is no indication that there is a plan to integrate the health knowledge of the majority of South Africans, such as the IHK, into health training programmes. Any plans for integration are generally restricted to hiring interpreters to alleviate communication problems of specific groups of Health Science's students working in peri-urban and rural environments whose residents do not have English or Afrikaans as a first language. Recently, there has been a move towards understanding the work of traditional healers, especially with the challenges faced in managing HIV and AIDS patients. (43,44) Again, these approaches are far from what the Alma-Ata and Ottawa Charters envisaged, i.e. that traditional healers would be brought on board in an

empowerment equation. Most attempts are aimed at convincing traditional healers to relinquish their healing vocation. (33,65)

Serpell (146), in his paper on bridging the gap between Western orthodox higher education practices and an African socio-cultural context, highlights the challenges facing universities to adapt education to the needs and aspirations of the post-colonial African state. He argues that education should afford students the opportunity to test formal Western theories against an African reality, and prepare them for the challenges they will face at work after graduation. Students should be invited to compare and integrate academic theories and perspectives with indigenous interpretations of experience. Mkhize (73) expresses concern for the vertical programmes that present a top-down, one-way transfer of knowledge, ideas, values and practices from developed to developing societies. He describes this as a form of cultural colonisation and asserts that the developed world continues to produce and market knowledge and technology to developing societies, while the latter remain mere consumers of these Western ideas and technology. The end product is irrelevant to the needs of the local populations and does not achieve the elimination of poverty, improve literacy rates or enhance development.

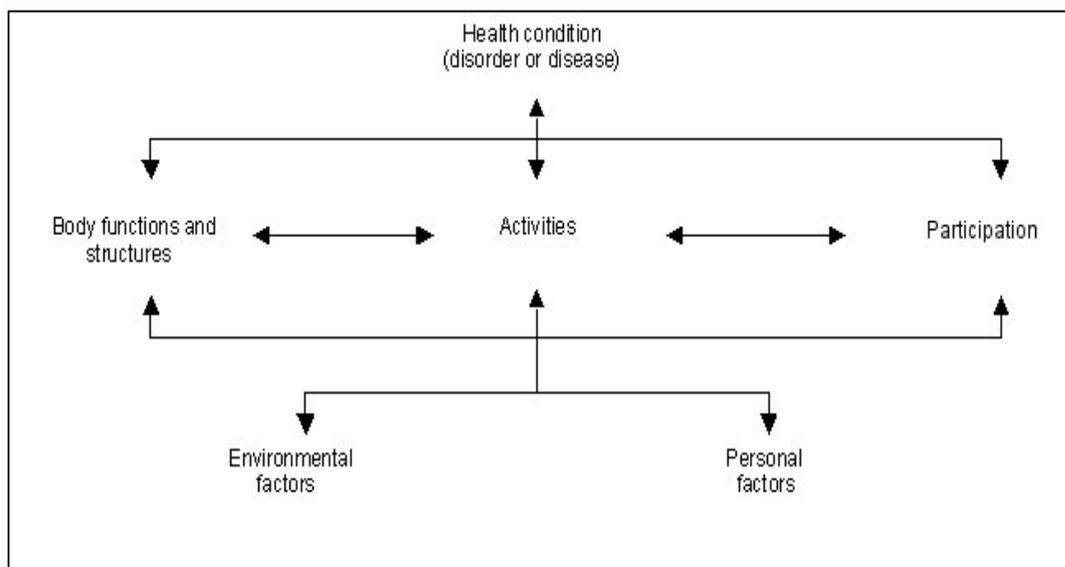
Mkhize's (73) concerns are not very different from Werner and Sander's (81) regarding the interference of organisations such as the World Bank in the implementation of PHC. Mkhize (73) expands this argument by saying that African indigenous frameworks for education are ignored because, like the people who espouse them, they belong to the category of marginalised knowledge. The result of this is the creation of African elites, as mentioned by Werner and Sanders (81), whose views and lifestyles are similar to their middle class Western mentors and different from those of their own (traditional) societies. An African worldview does not mean that every member of a culture must subscribe to it, in the same way as not every European subscribes to an individualistic way of life. However, ignoring the indigenous African worldview limits the health professional's ability to deal with people from different cultural backgrounds. Whittaker (108) challenges the educationalists/trainers regarding their response to a social contract in health education, and suggests that there might be the need to adopt responses that have not been thought of before, such as the integration of IHK carried by older Xhosa women.

### **2.5.2 Steps already achieved by Health Science Faculties**

Through this literature review it has been shown that many indigenous communities struggle with an exclusively Western-type of health management system. Broad and Allison (116) emphasise that when traditional health care is placed on an equal scale with Western health care and each is respected in its own right, people who may have been distrustful of Western

health care would be willing to access both systems and take control of their own health needs. Many medical curricula have recognised the need to shift from a professional disease-specific approach to a client-centred curriculum where the needs of the client are the focal point. Professionals in some institutions have come together to develop interdisciplinary teams with the goal of delivering comprehensive and holistic health care curricula to students. In these integration attempts, the medical, rehabilitation and nursing curricula are key role players.

The International Classification of Disease, Health and Disability (ICF) recognises the delicate interaction between the individual, health and the environment. It is within this approach that WHO (147) designed the diagram in Figure 2.1 to illustrate how this interrelationship is played out.



**Figure 2.1: The International Classification of Disease, Health and Disability (ICF)**

The diagram in Figure 2.1 shows that disease does not occur in a vacuum. There is always some interplay between disease, the person and the environment, as already noted by Katzellebogen. (82) This is not far from Malena's (43) perception about how African people perceive and define illness. Many researchers have suggested that traditional African people have never stopped using IHC (43,44) conditions in a one-sided manner. (147) Fortunately, as already mentioned, many Health Sciences faculties are already shifting to a community-based approach, and are attempting to explore different health facets at community level, with students doing home visits, during their clinical exposure. (110) Students follow an assets model (111), whereby they analyse strengths as well as challenges the patient may

experience in the home and use the available assets to help patients prevent admission or re-admission to health institutions.

Kuipers and Allen (148) echo the views of the community health forums inKhayelitsha, that the challenge of transforming the Health Sciences curricula to one that is more suitable to local needs and culture, requires the collaboration of all stakeholders, with the main participants being those communities who will feel the main impact of the curricula - as clients of health care professionals. They propose that this process should be supported by: (a) a multidimensional development approach that includes change at the systems and organisational levels; (b) appropriate intermediate level and professional training on community work; and (c) conceptual, policy and financial support from international bodies. This is supported by Poudyal et al (117) who identified four aspects for scaling up health activities: (a) role-playing and replication of activities; (b) horizontal and vertical integration; (c) supportive infrastructure; and (d) model building and piloting of the model. (149)

### **2.5.3 Summary of section**

The knowledge of caring and healing that is held by older Xhosa women must be seen as the first strategy for maintaining health and containing illness within the home. The home can only act as a gateway for promoting health through the support given by these women. The Western health care system has caused a split between the middle and older generation of women, with health care workers chastising the middle generation for using the IHK of older Xhosa women prior to visiting the health care facilities. The section reviewed the role bestowed upon the clinical nurse practitioner as mini-doctor. It was noted that many of these clinical nurse practitioners are from the same generation as the older Xhosa women who use IHK, and they too in their preconceptions might still carry the IHK or of being cared for by an older woman in the home. A proposal was put forward for clinical nurse practitioners to develop a bridge/pathway between the home and PHC services, in which a back and forth movement of health knowledge could emerge. Section 2.5 ended by advocating for the inclusion of the IHK held by older Xhosa women in the Health Sciences curricula.

## **2.6 CONCLUDING STATEMENT**

There is a need to include the definition of health of the indigenous peoples of the world into the 1948 WHO definition. IHK and locally developed health strategies are still used in many African homes and communities, and as such should be recognised and included in health promotion programmes. Berg's outline of indigenous psychological approaches and how they equate to modern approaches, illustrated the value of the approach used by indigenous

healers to mental health/illness, and could be a starting point for the integration of the two approaches.

With regard to science and indigenous knowledge research, it is important that the tools of one are not used to analyse and understand the foundations of the other, or to draw conclusions about a system of knowledge that cannot withstand scientific scrutiny, and vice versa.

The lofty goal and attempts made by the post-apartheid government to bring equitable health services to the people of South Africa have not yet been achieved and health inequity persists for the most disadvantaged people who are most in need. There is a need to consider alternative community-based strategies such as the IHK held by older women, especially those who are known in their communities for their healing and caring approaches. The introduction of the clinical nurse practitioner at the primary level of care brings hope to the building of bridges and healing the split between the home and PHC services. A good starting point for this reconciliation is with integration of IHK systems into the curricula of Health Sciences Faculties, and the training of health professionals that have the competency to enter and work effectively across all cultures of South Africa.

## **CHAPTER 3: METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter describes the main features and nature of the research design that informed and drove the study. The process of community entry and of developing community partnerships is outlined, and the piloting phase is described. The study population, sampling strategies, and the methodology of the study are presented. The data collection process and the measures that were put in place for data-capturing, storage and analysis, are described. The steps that were taken to achieve reliability and trustworthiness of the collected data and of the study are given. The chapter ends with a concluding statement.

### **3.2 DESCRIPTION OF THE RESEARCH DESIGN**

The research design for the study was built around four distinct features, namely: (a) descriptive, exploratory and retrospective; (b) ethnographic; (c) qualitative and reflective; and (d) feminist and emancipatory. The main features and nature of the research design that informed and drove the processes of the study are described below.

#### **3.2.1 Descriptive, exploratory and retrospective study designs**

Descriptive, exploratory and retrospective studies are essential when breaking new ground because they afford space for reflection about events and facilitate the probability of yielding new insight and an understanding of the area in the research process. (82) In this study, the IHK carried by older Xhosa women in their care of health problems within the home situation is described, and most importantly an attempt is made to present the interpretation of these practices through the eyes of the older Xhosa women. There are two major challenges with descriptive retrospective studies. The first is related to the people who are being investigated – that they should be well represented. (2) The second challenge is related to the retrospective nature of the design, whereby time lapses could cause vital elements of the information to be forgotten or presented in such a manner that it compromises the validity of information. (82) This study has taken this into consideration by using Zonke's (3) study outcomes.

#### **3.2.2 Ethnographic study designs**

Ethnographic study design methods were selected to ensure that a suitable approach was utilised to explore and describe the study setting, sampling strategy and methods of data collection. In an ethnographic study, the participant culture is understood from the point of view of the people who inhabit and inherit that culture. The human community, as opposed to

the rest of the environment, is seen to have social characteristics that are the product of the interaction between its members. It is assumed that the features of social organisation that are significant in community life are known to its members and discoverable by the investigator. (1,2,4) This is the reality of the understanding and interpretation of the older Xhosa women pertaining to which health problems were managed within the home, and this reality assisted the researcher to develop an interpretive approach on how and why these health problems were managed within the home situation in a rural context. (3,17-19)

An ethnographic study requires a close examination of the context in which the participant culture lives, to discover and understand how this has influenced the actions of the participants, for example, in managing their health and illness in the home situation. Zonke (3) asserts that knowledge regarding the healing properties of certain herbs is carried by word-of-mouth from generation to generation. Because of this, different ethnographic research methods were used in this doctoral study to collect data, such as: FGDs with the older Xhosa women, in-depth interviews with key informants, and transitional opportunistic conversations. These ethnographic methodologies enabled the researcher to explore data such as:

- narratives by the older Xhosa women of life stories and personal experiences regarding wellness and illnesses, and how health problems were managed within their home situation by giving voice to their prior knowledge of healing;
- life histories relived through questioning and extrapolation of who were the older Xhosa women, and in particular who were the elite older Xhosa women; and how they engaged in inquiry and used various management strategies to deal with health problems.

### **3.2.3 Feminist and emancipatory research design**

Feminist and emancipatory research designs, though different in nature, share a common theory about power and domination. Emancipation research speaks to the theory of minority groups and the process of giving voice to their cause. (1,4) The older Xhosa woman, being female, carries a tripple burden – firstly her healing knowledge is classified as ‘merely’ part of her role as a woman (and as such is not validated in the same way as a male or female whose skills and knowledge are certified outside the home) (40); secondly, her knowledge is classified by the Western culture and paradigm - which sees itself as the arbiter of modern, progressive knowledge – as being part of the group of minority knowledges which have been ignored by allopathic medicine. (40) Lastly, because the older Xhosa woman passes on her knowledge by word-of-mouth, she faces the challenge of not having a voice to carry this knowledge into the global arena. This is mainly because her knowledge is caught in an environment that lacks access to the global arena due to factors, such as illiteracy and

technological deprivation. (73) This study explored the notion that in the rural Eastern Cape there are some indigenous older Xhosa women who still carry IHK and that this knowledge can be brought to the surface, investigated, documented, validated, and made more available to a wider audience.

Feminist researchers, such as Clough (40), suggest that all over the world, women in general have repressed and relinquished their overt healing powers and skills to dominant, Western-trained health scientists. They are now unconsciously, but routinely, practising their vocations of caring for pregnant women, assisting with births, raising children, caring for the ill, and mediating in family conflicts, 'in the dark', and without acknowledgment for their contribution to society. These feminist researchers (7,40) show how women, like the indigenous/local knowers, are situated between two conflicting forces – the forces of the West which claim scientific knowledge; and the forces of the indigenous community which claim to have equally valid skills and knowledge learnt and carried from the cradle. Native knowers throughout the world present common experiences of colonisation and domination by forces predominantly from the West, which continue to maintain their superiority by defining 'the other'.

Some researchers appear to have jumped on this bandwagon by being selective in the type of research questions to be explored in communities. This is already evident by the power of inequity embedded in what gets studied in the first place. (40,73) Both feminist and emancipatory research raises questions that challenge this dominant power. Likewise, the ethnographic study design used in this research, enabled the researcher to focus on the healing practices of the older Xhosa women, and in this way tried to contribute towards the process of emancipating and validating their IHK.

### **3.2.4 Qualitative reflective research design**

Qualitative methods include a reflective process at every stage of the study. It is this reflective process that guided the researcher to recognise the importance of the interconnectedness and interaction of the study's different design components. Traditional research design is based, implicitly, on the positivist ideal of the objective and disinterested scientist. The positivist ideal emphasises that the choice of research approaches and methods should be determined by the research questions to be answered. Maxwell (150) differs from this when he asserts that research decisions are more personal desires and it is important to carefully assess the implication of these decisions to the qualitative inquiry. He asserts that qualitative researchers are driven by four main motives: (a) personal purposes; (b) practical purposes; (c) the value component of research questions; and (d) the process as the vehicle by which critical events and actions take place in qualitative research.

#### **3.2.4.1 Personal purposes**

Personal purposes embrace the commonly-driven need to influence an existing situation or political stalemate. Personal purposes could even be a deeply-rooted individual desire or need that has little bearing on the 'official' reasons for doing the study. These desires must be carefully examined since they may introduce bias into the study design, and may have implications for the methodology and conclusions drawn - they can be skewed and one-sided and carry the danger of creating flawed results. On the other hand, when these desires are examined for what they are, they can make an immense contribution towards the insight, theory and deeper understanding of the data gathered about the phenomenon under study. (150)

As this is a study built around the contribution of older Xhosa women and their management of health problems in the home situation, it was important for the researcher to address the issue of personal purposes and its influence on the results of this study. Consequently, the researcher reflected on women who might have made an impression on her own growing up as a Xhosa woman and how this has influenced the way she perceives health containment and maintenance within the home situation (see Appendix G).

#### **3.2.4.2 Practical purposes**

The second motive that may drive qualitative research are the practical purposes or goals of the study, for example, if the driving or personal force of the study is the need to change a situation, then the study needs to incorporate practical steps that lead to how change would be achieved. The starting point is to explore the current situation, asking questions such as, what is happening and why; and following this with an exploration of the practical steps that need to be taken to achieve change. (150,151) In Chapter 1 of this doctoral thesis, the researcher described the current situation in community health centres and clinics at the primary level of care, as being overcrowded with clients who appear to predominantly present with minor health ailments. The purpose of this study and its objectives, as iterated in Chapter 1, gives a framework for accomplishing the goal of the study - as being to alleviate overcrowding by utilising the assets (i.e. IHK) inherent in the homes and communities from which clients come as the first line of health care. How this goal is to be achieved is the subject of the study.

#### **3.2.4.3 The value component of research questions**

It is important to the study design that research questions are framed in such a way that they contribute a value component that practically assists in achieving the goals of the study. Both the key research questions and the objectives of this study are centralised around the core issues of: IHK; health problems within the home situation; and older Xhosa women as the

carriers of IHK. These core issues provided the framework for what key research questions were to be asked in order to collect relevant data which would add value to achieving the goals of the study whereby the findings from this study with regard to IHK in the management of health problems within the home situation by the older Xhosa women would be an asset to alleviate the overcrowding in clinics by clients presenting with minor health problems, rather than to simply collect data about IHK.

#### **3.2.4.4 *The process as the vehicle that carries the critical events and actions***

In qualitative research, the process becomes the vehicle by which critical events and actions take place. Maxwell, quoting Merriam (150), states that, “the interest (in a qualitative study) is in a process rather than outcomes”. The process used should lead to the outcomes. Miles and Huberman (1) argue that there is much recent research to support the claim that field research is far better than solely quantified approaches when it comes to developing explanations for what we call causality. Quantitative research has a tendency to examine whether, and to what extent, variance in *x* causes an impact on variance in *y*. Qualitative research, on the other hand, tends to ask how *x* plays a role in causal processes in *y*. Mohr (152) and Ragin (153) have defined this as the distinction between variance theory (variable-orientated) and process theory (case-orientated). Variance theory deals with variables and correlations amongst them; it is based on analysing the contribution that differences in values of particular variables make to differences in other variables. Process theory, in contrast, deals with the events and processes that connect them; it is based on an analysis of the causal processes by which some events influence others.

This approach and strength of qualitative study coincides firstly with the broader understanding of a majority of the indigenous people of the world regarding health and illness (7,8); and secondly it resonates well with how health and illness in Africa are explained by way of process reasoning, with the individual being seen as part of and interacting within their own context. (43) Maelene (43) further expands that when it comes to health and illness and an African interpretation of these, contexts and processes become critical. From the context and process of the actual events that led to health or illness, follows the quest to understand illness by way of questions such as, ‘why?’ and ‘who?’ These are uppermost in the minds of traditional Africans. From here causal explanations can be extrapolated. Regarding the older Xhosa women in this doctoral study, questions such as the following were asked: How did the older Xhosa women come to the conclusion that the person was having a specific health problem? What management strategies did they use and when do they conclude that these strategies are not working? Who do they refer the ill person to and why? The researcher asked questions of both the immediate and the extended family

members of the older Xhosa women regarding the skills involved in the managing of health problems within the home situation. Information gained from these sources was enhanced by means of transitional opportune conversations/encounters (which involved speaking to village travellers, walkers, etc.), which further enriched and supported the process-orientated approach. Feedback workshops were conducted at various stages of data collection and analysis to enhance the continuity of the process and to validate findings.

### 3.2.5 Summary of indigenous health knowledge research and methodologies and their impact on this study

The researcher explored the literature from four similar IHK studies conducted by other researchers. From these studies similar methodological aspects were identified and contributed to this thesis. These methodological aspects are summarised below in Table 3.1.

**Table 3.1: Summary of the four indigenous health knowledge studies**

Article and author	Summary of critical aspects of each study, related to this thesis	Contribution to the thesis
1. Understanding health and illness amongst the Maori people: research at the interface between science and indigenous knowledge (IK). Durie (46)	<p>By being sensitive to culture and harmonising both IK and Western approaches during research, researchers can achieve better co-operation with participants.</p> <p>Better co-operation between researcher and indigenous participants assisted Durie to understand that for the Maori tribe wellness means more than the removal of a symptom.</p> <p>Health was measured according to participation in tribal activities and inclusion in family celebrations. Health was seen as cultural identity and part of the 'Self'. Being a healthy person within the Maori tribe was seen as being a Maori.</p>	<p><i>Cultural sensitivity:</i> The researcher was aware of being culturally sensitive during the research process and tried to conduct research in the natural environment of the participants - which for the older Xhosa women was their homes.</p> <p><i>Definition of health:</i> Being healthy, according to the Maori, is equivalent to being a Maori.</p> <p><i>The meaning of health and 'Self':</i> The meaning of health was evaluated and what the older women used as a yardstick to measure health and how far was this from the Maori understanding of health.</p>

<p>2 Improving health outcomes in diverse populations: Competency in cross-cultural research in indigenous Pacific Islander populations.</p> <p>Palafox, Beunconsejo, Riklon and Waiztfelder</p> <p>(115)</p>	<p>The unravelling of the complex health situation and determining the changes that need to be made is dependent on the dominant culture in a way that bridges cultural paradigms. It is not sufficient to train more indigenous Pacific Islanders to do more western-style research. There is a need to train Westerners to understand IKS.</p>	<p><i>Language issues:</i></p> <p>Interviews were conducted in Xhosa which is the mother tongue of the older Xhosa women. The researcher speaks this language as fluently as the participants and comes from a similar cultural background.</p>
<p>3. Predictors of indigenous healing used amongst Samoans. Mishra, Hess and Luce (8)</p>	<p>These researchers emphasised the use of the correct terminology when conducting IK studies. In their study they opted to use the term 'indigenous' in contrast to terms such as 'native' or 'traditional' as these two terms were seen as fixed and not evolving, as IK does.</p>	<p><i>Terminology used:</i></p> <p>The term 'indigenous health' was used for the healing practices of the older Xhosa women in their home situation. An attempt was made to avoid terms such as traditional healing/healers</p>
<p>3.The use of medicinal plants and pharmaceuticals by indigenous communities in the Bolivian and Amazon. Vandebroek et al</p> <p>(121)</p>	<p>Vandebroek measured how distance from health facilities influenced the use of IHK. The study showed that increased distance from the health facility was directly proportional to the increased usage of IK plants</p>	<p><i>Distance from health centre:</i></p> <p>It was ensured that in the selection of participants of the study, some were closer to the health facility and others further away. The researcher has described how these distances influenced the practices of the older Xhosa women.</p>

### 3.3 RESEARCH PLAN FOR THE PREPARATORY STAGE OF THE RESEARCH

In the preparatory stage, an account of the researcher's prior knowledge and own thoughts, which influenced the conceptual framework and research processes, is given. The study setting, the process of community entry and developing community partnerships, and a description of the pilot study and its impact is outlined.

#### 3.3.1 Prior knowledge that researcher brings to the study

The researcher reflected on her lived experience of having encountered and been under the mentorship of five women in her early development; and how she perceived that these experiences have impacted on her development and actualisation, at the personal and academic level, and along her journey of exploring this topic. Consequently, these women have also had an indirect influence on how this thesis has developed. (35) The rationale for this exercise was an attempt to delineate part of the subjective stance that could undermine

the objectivity of this thesis and to use those elements that could strengthen and bring value to the study. (1) Three themes were identified from the narration of the encounters with these women:

- a. transfer of attributes and skills related to growth and development;
- b. transfer of values and principles; and
- c. knowledge and skills that the researcher perceived that the older women had.

A narrative of the researcher's encounters with the five women that mentored her is presented in Appendix G.

### **3.3.2 The study setting of the research**

The 18 villages of Gusi where the study was undertaken are in the district of Elliotdale in the Eastern Cape Province of South Africa. Elliotdale lies between Umtata and East London, and between the Umtata and Bashee Rivers (see Figure 1). The 18 villages of Gusi lie directly on the Wild Coast of the Eastern Cape. Enclosed by the boundaries of the sea, the area stretches inland for about 16 miles. The people that reside in the 18 villages of Gusi are classified as the Amabomvane tribe. This area is sometimes called Bomvanaland. The Amabomvane tribe spreads over two thirds of Elliotdale district and includes the neighbouring Mqanduli district. Bomvanaland has numerous rolling hills, meadows, rivulets and rivers where bushes and trees grow. The roads are gravel with *dongas* (large potholes) that make traveling by car difficult. Spring and summer bring reasonably high rainfalls that assist subsistence farmers with green pastures and with grazing fields for their stock (cattle, sheep and goats) as well as growing *mealies* (maize) and vegetables for family use.

This district was purposefully chosen for the study for the following reasons:

- a. the predominant cultural group are Xhosa and still hold onto their cultural values and norms;
- b. high levels of illiteracy prevail, hence the researcher presumed that there were low levels of being influenced by western approaches to health management;
- c. there is a district hospital in this area and the researcher wanted to study the impact of this on the health practices of the older Xhosa women and use of IHK (121); and
- d. there is a good spread of villages, with some being in close proximity to the hospital and others being far away. For the researcher, it was important to see the impact of these distances on the IHK carried by the older Xhosa women. (121)

Madwaleni Hospital (will later be named the hospital) is at the heart of Bomvanaland, and stands amidst the sparsely populated cluster of approximately 18 villages. There are eight clinics that are 0-35 kilometers from the hospital and refer clients mainly to Madwaleni

Hospital. During the period of research the majority of the clinics were still new and some not fully functional. The hospital was the main public health provider at district level of care.

### **3.3.3 Researcher's community entry and development of community partnerships**

The researcher used two approaches for community entry and the development of community partnerships:

- a. meeting with the Chief of the 18 villages of Gusi (throughout this study, he will be called the Chief); and getting permission from him to implement the study; and
- b. meeting with the Superintendent of the hospital, and getting an understanding of the health status of the 18 villages of Gusi and his perception of the health-seeking behaviour of the people of these villages.

Other people that assisted the researcher with community entry and the understanding of the 18 villages of Gusi were:

- Sister A: Key informant/liaison between the superintendent and the Chief
- Manager of the hospital
- Law student: Researcher's research assistant and assisted with identification of the elitist Xhosa women in the 18 villages of Gusi. She is from outside this area. It is only her husband and in-laws that are from this area. She was referred by the hospital staff to the researcher.

Below is a summary of the discussions the researcher had with the Chief, the Superintendent, Sister A and the hospital manager:

#### *Discussion with the Chief:*

The outcome of the discussion between the researcher, the Chief, his Chieftains and the Paramount Chieftainess, reinforced the information in Chapter 1 of this thesis, regarding the Amabomvana tribe and it was confirmed that the Amabomvana tribe still believed strongly in rituals and ancestors. The emerging themes showed that these three leaders were very aware of the challenges facing the Amabomvana people and their health. They are concerned about the lack of integration of their knowledge into mainstream health care, and see this as a disjuncture with regards to health. There is a general perception that Christian religion, education and health systems have undermined the IHK held by the Amabomvane people. Major areas of concern and health challenges included: TB, HIV and AIDS; the emergence of new challenges such as abuse of liquor; and the change of governance from the chiefs being the sole custodians of the rule of law and the emergence of councilors linked to central government. The backwards and forwards movement suggested by one of the Chieftains as a solution to the health problems facing the Amabomvane tribe, needs further

exploration (see terminology used in this thesis, p. xxvi). A full account of my interaction with the Chiefs of Madwaleni is presented in Appendix E.

*The Superintendent, the retired registered nursing sister (Sister A) and the hospital manager:* The superintendent sees the value of research as a tool to improve health services. He is concerned about the relationship between the hospital and the people of Gusi. He is aware of the challenges and seems to have a plan to address these. He and the matron are proud of the achievements they have gained regarding the therapeutic management of HIV and AIDS. Sister A appears to be the liaison between the hospital and the people of Gusi. She assisted the researcher with the cultural aspects related to community entry, as well as methodological adjustments that the researchers needed to implement. She further suggested that the researcher not to have FGDs for the elite older Xhosa women, as they do not like sharing their knowledge with other people. She suggested that interviewing them on their own was a better strategy.

*Perception of the manager regarding the status of the hospital for the 18 villages of Gusi:*

The manager perceived that hospital is enjoying steady progress. There is a fully-fledged HIV and AIDS programme run by two doctors; and doctors who are doing community service at the hospital relieve the doctor's load. There is a need to strengthen the staff through accreditation of middle management. A weakness would be the shortage of staff especially in the maternity ward. Identified needs for improvement included: improving patient understanding of treatment; educating patients about lifestyle choices and how these impact on health, e.g. alcoholism (there is a high percentage of alcoholism in the surrounding areas), patients become re-infected with TB due to lifestyle choices; and conducting more health education through the clinics. An *Imbizo* (village meeting) was called in April 2007 and focused on the need for home-based management of HIV/AIDS and TB-related illnesses.

### **3.3.4 Piloting the methodology of this study**

A pilot study was conducted with five older Xhosa women (aged between 65 and 75 years) and one middle-aged man in the rural area of Buntingville and Mdizeni. The older women were chosen by the principal of the secondary school of the area. The middle-aged man came to the study by default as the principal had hoped that the researcher would meet the wife of this man, whom she perceived to be knowledgeable on management strategies for health problems within the home using IHK. This couple lived on a farm and could be classified as 'Rastafarian'. The farm boasted a wide variety of herbs.

The pilot study took two days. A social science student assisted as a scribe. With regard to the research tools and the process of data collection, the researcher piloted the exact

method for storage, transcription and data analysis that she was going to use in the actual data collection.

#### **3.3.4.1 Aspects that emerged from the pilot study relevant to this study**

The following aspects from the pilot study impacted on the research:

- a. The five older Xhosa women from the pilot study explained health problems they managed at home from a broad daily living perspective, beginning with assisting the grandchildren to prepare for school, engaging in daily activities from breakfast to supper, planting of the gardens, and ending with ensuring that the grandchildren were all asleep and safe. It thus became evident that the researcher needed to clarify what people understood by health and illness, and then to follow up with what health problems they managed at home.
- b. Distances from the health services appeared to have an impact on health-seeking behaviour. One older woman in the pilot study, who lived close to the health facility did not want to speak about her use of IHK to manage health and illness in the home and kept saying, “we no longer practice those things”. However, the researcher observed that although she denied using IHK management strategies, she was determined that when it came to certain conditions, she would not want her children to go to the hospital, for example, to give birth. She saw her methods of assisting her children to give birth as being better than those found at the hospital. The issue of the impact of distance from the health facility on health-seeking behaviour increased the researcher’s awareness that when selecting participants for the FGs, she needed to include people who were at various distances to the health facility - both near and far.
- c. As the researcher was conducting in-depth interviews with each older Xhosa women, she noticed that the grandchildren and daughter-in-law kept giving their input on how the older Xhosa women supported the health of the family. One daughter-in-law affirmed the trust she has in her mother-in-law in assisting her to give birth. This further affirmed that the researcher should get input from family members to validate the findings of the study.
- d. The five women in the pilot study had good clarity on health management strategies in the home situation and this affirmed that elite older Xhosa women should be included in this study.
- e. During one in-depth interview with one of the women in the pilot study (who had extensive knowledge of IHK), a second older Xhosa woman later joined in the conversation. The researcher noticed that the first older Xhosa woman, who appeared to be knowledgeable about IHK, became less talkative and less willing to share her knowledge once the other older Xhosa woman joined in the conversation. This is

similar to the study conducted by Bell amongst Aboriginal women in Australia. (137) This confirmed the advice given by Sister A about the need to interview the elite older Xhosa women alone and not in a FG as they do not like to share their knowledge. One of the older Xhosa women ended her discussion by calling for the return of undalashé - which in this context meant the old ways of keeping respect, cohesiveness and the stability of the villages.

### **3.4 RESEARCH PLAN FOR THE PRIMARY OBJECTIVES OF THE STUDY**

In this section, the study population and the selection of the study sample and sampling strategies are outlined, and issues of instrumentation and the process of data collection are explained.

#### **3.4.1 Study population**

The study population was made up of two groups:

- a. All the older Xhosa women above the age of 60 years from the 18 villages of Gusi, Elliotdale (see terminology used in this study, p. xxiv). (3,9,10)
- b. Family members of all older Xhosa women above the age of 60 years from 18 villages of Elliotdale.

#### **3.4.2 Study sample and sampling methods**

The 18 villages of Gusi functioned as clusters to participate in the study four clusters were organized from the 18 villages with some village clusters being closer to the hospital and others being far away and the study sample was selected from these 4 clusters. The study sample was further divided into:

- a. Primary study sample:
  - the older Xhosa women who formed the four FGs
- b. Secondary study samples:
  - Elite older Xhosa women
  - Family members of the elite older Xhosa women
  - Transitional opportunistic conversers

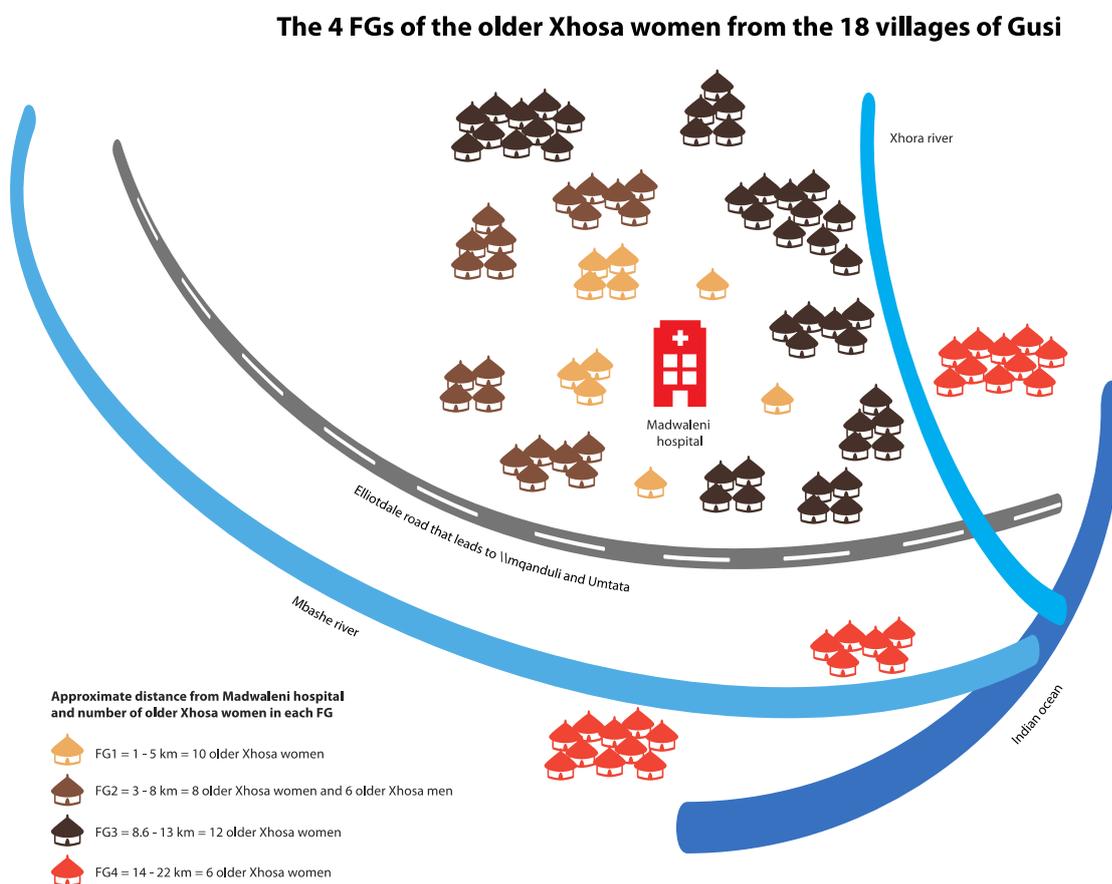
##### **3.4.2.1 Primary study sample**

The primary study sample was made up of 36 older Xhosa women over the age of 60 years who were purposefully selected and voluntarily participated, and were drawn from the villages in the study setting. Firstly, the Chief selected the older Xhosa women from the 18 villages and the researcher then listed their names. Snowball sampling was used in which these older women identified others who could participate. The main inclusion criterion was

that they should be over the age 60 and should be current residents of the villages. The total number of women in the study was 36. The pattern followed was:

- the first cluster of four villages included ten older Xhosa women;
- the second cluster of four villages included eight older Xhosa women and six older men. These six older Xhosa men had heard that there was a project on health issues and they simply arrived at the FGD, and so it was difficult not to include them. It was also clear that with the inclusion of these men, this FGD would come out with unique characteristics;
- the third cluster of five villages included 12 older Xhosa women;
- the fourth cluster included six older Xhosa women.

Below is a schematic presentation on the selection of older Xhosa women from the main study area:



**Figure 3.1: The four FGs of the older Xhosa women from the 18 villages of Gusi**

### 3.4.2.2 Secondary study sample

The secondary study sample comprised of key informants to validate the findings from the primary sample. These consisted of:

- a. *Sixteen (16) elite older Xhosa women:* Initially the plan was to ask the Chief of each village to purposefully select 16 elite older Xhosa women and the women in each of

the FGs were also going to identify elite Xhosa women. Furthermore, the husbands of the older Xhosa women, the daughters and the daughters-in-law were to suggest names of women known and consulted in each village for their IHK. Four women who were mentioned by all four groups in each village were then to be selected. The elite Xhosa women were finally identified in the following manner:

- From the two clusters of villages farthest away from the hospital: Four of the elite older Xhosa women participated in the FGDs with the older Xhosa women. They seemed to be trusted by the other older Xhosa women as elite carriers of IHK.
  - From the cluster of villages directly close to the hospital: Three women were identified by the research assistant, while one woman had participated in the FGDs.
  - From the cluster of villages farther away from the hospital: One elite Xhosa woman identified herself, another was identified by the lecturer from Stellenbosch University who had worked as a doctor at Madwaleni Hospital for more than five years.
  - In addition, five of the older Xhosa women from the pilot study in Buntingville and Umdizeni were identified as elite older Xhosa women, as the principal of the secondary school in the area had chosen them for their extensive knowledge and experience of indigenous health matters, which had led to them being consulted by other older Xhosa women in the village.
  - The researcher also classified Sister A as an elite older Xhosa woman for her knowledge and contribution to the health problems that are managed by the older Xhosa women in their home situation. This brought a total of 16 elite older Xhosa women to this doctoral study.
- b. *Four purposefully selected family members of the elite older Xhosa women:* The rationale for selecting this sample was to find out who was consulted when a family member was ill and why. Those selected were family members of the elite older Xhosa women who were willing to have the researcher approach their family members to participate in the study. The target sample included:
- the daughters and daughters-in-law of the older women; and
  - the grandchildren of the older Xhosa women. Zonke (3)
- c. Families who had experienced critical incidents whereby the elite sample had been called upon for help in containing the health situation: The aim was to call upon the 16 elite older Xhosa women to provide information about families whom they had successfully assisted with the containment of health problems of at least one family

member, and families in which their containment strategies were unsuccessful. The researcher wanted to include this balance of successful and unsuccessful encounters whom they assisted during critical incidents. However, when the researcher visited one of these families at first the woman (who was a teacher and a principal) seemed eager to talk about the incident, but then began to ridicule the IHK of the elite older Xhosa woman who had assisted her. Beyond this encounter, none of the elitist women were willing to talk about the patients they had managed. This appeared to be similar to the elite aboriginal women of Australia who sometimes pretended ignorance as a way of protecting their knowledge. (137)

- d. *Visit of the 16 elite older Xhosa women group by a research assistant from each of the four villages at the end of each week:* It was also planned that after completion of the above four steps of data collection, for 12 consecutive weeks, the research assistants would ask these participants to recall and narrate events relating to how they had contained health problems that emerged each week. This part of the study had to be discarded as it became clear during interviews that the elite older Xhosa women that were from the 18 villages of Gusi, were reluctant to speak about their IHK or the critical incidents they had managed.
- e. *Transitional opportunistic conversers (TOC):* While driving around the villages the researcher would meet certain individuals that fit into of the layers of the study. She would give these individuals a lift then introductions would happen. Then the researcher would explain why she was there amongst the 18 villages of Gusi. Then these individuals would start a dialogue regarding the research topic. These conversations brought unplanned insight into the complexity of the research topic. This approach is similar to the process of networking that Webber (154) describes. He maintains that as human beings, we have the past, the space in-between and the future. His perception is that the space in-between is the most critical space for developmental work as it gives you another insight that is different from the past and still not yet there in the future. Networking capitalises on this space in-between. These transitional opportunistic conversations were never asked to contribute anything to the research question. The introductions became the instrument that linked them to the research question. They tended to provide another perspective to the research question and reminded the researcher of the complexity of the research question. Below is the list of the transitional opportunistic conversers:

Five encounters were identified as transitional conversations with the people from Gusi village:

- Transitional conversation 1: Two young wives (the makotis)
- Transitional conversation 2: Village mourners
- Transitional conversation 3: Retired clinical nurse practitioner
- Transitional conversation 4: Concerned clinical nurse practitioner
- Transitional conversation 5: Chief

These encounters were recorded in the researcher's log book immediately after the encounter.

### **3.5 INSTRUMENTATION AND DATA COLLECTION PROCESS**

Instrumentation and data collection proceeded along the three main lines:

- a. Primary study sample: FGDs with the 36 older Xhosa women using an interviewing schedule.
- b. Secondary study sample: Individual in-depth interviews using an interviewing guide with:
  - the narration of life stories of elite Xhosa women and
  - family members of the older Xhosa women;
- c. Transitional conversers: Introductions elicited the conversation regarding the research topic.

#### **3.5.1 Focus group discussions (FGDs) with the main study sample**

Four FGDs were conducted, with the guidance of an interview schedule, with 36 older Xhosa women from the 18 villages of Gusi who were deemed to be the carriers of IHK. The interview schedule that had been used in the pilot study in the rural area in Buntingville was used (see Appendix C). It focused on the main objectives of the study.

In each FG, the women knew each other as they came from the same clusters of villages. All FGs were conducted in one of the homes of the older Xhosa women except for the first FGD, where this was conducted in one of the chiefain's houses. Each discussion varied with regard to participants' responses to the research questions. Distances from the health facility tended to have an impact on this variation. What follows is a description of the four FGDs.

##### **3.5.1.1 Focus Group 1**

The participants in this FG resided closest to hospital. Ten older Xhosa women came from four groups of villages. The Chief had asked one of his chieftains to accommodate the FGD in his house, which was not far from the beer hall that was close to the hospital. It was a warm, sunny day and everyone sat on chairs in a circle outside. The presence of the beer

hall was a distraction and challenged the concentration of the older Xhosa women, who appeared to be more interested in joining the people at the beer hall. The researcher allowed them to send one of the women to buy beer in a plastic bucket. This appeared to resolve the problem and their level of concentration was restored. This FGD started at 10:00 and ended at 13:00.

### **3.5.1.2 Focus Group 2**

The eight women and six men who made up this FG resided slightly farther away from the hospital and hailed from another four groups of villages. The FG was conducted in the house of a Chieftain. Two wives from this household participated. The house was situated next to the road going to Elliotdale, Mqanduli and the main town of Umtata. There was a general sense of restlessness amongst the participants. The men were not supposed to attend in the first place and the researcher felt that the restlessness had its origins in the older men noticing a car standing at the Chieftain's house. They wanted to be sure that the opportunities for interaction that came with the car would not pass them by once they had joined the FGD. It was difficult to chase the men away. In retrospect, the researcher is of the opinion that their presence inhibited the older Xhosa women from freely engaging in the discussion. It was difficult to ask the women whether their husbands were still alive as the six older men tended to dominate the discussion. This situation was redeemed during the feedback workshop, which was not attended by any of the men - it was their own choice not to come. This FGD started at 10:30 and finished at approximately 13:00.

### **3.5.1.3 Focus Group 3**

This FG, which was farther away from the hospital, comprised 12 older Xhosa women from six further groups of villages. The FG was conducted in the house of the Chief and his first wife. The researcher later discovered that the Chief had two more wives, each with her own house. The second wife lived close to the first wife, in a far simpler homestead than that of the first wife whose house is called '*komkhulu*' or the Great Place. There was a calmness in this FGD, as well as a willingness to explore IHK at a deeper level. This group comprised a cluster of older Xhosa women whose husbands were Chieftains or headmen. This FGD started at 9:00 and finished at approximately 15:00. Teas and lunch were served, with the researcher giving support by buying foodstuff to enhance the meals.

### **3.5.1.4 Focus Group 4**

The six older Xhosa women in this FG lived the farthest away from the hospital. They were close to the sea and the group discussions were held in the house of a mother who had a disabled child and whose daughter worked at Madwaleni Hospital. In this FG, it emerged that two of the women felt quite strongly about IHK. They were later selected as elite older Xhosa

women. One participant was neutral about IHK and three other women were cynical about it, but appeared to be intoxicated. These three somewhat inebriated ladies wanted the whole FG to hurry, as it appeared that they wanted to go to refresh themselves with alcohol. None of the three women who were inebriated were present when the researcher returned. This FGD started at 14:30 and ended at 17:00.

### **3.5.2 In-depth interviews with the secondary study sample**

The researcher conducted individual in-depth interviews with elite older Xhosa women and their family members to validate the findings from the primary study sample. Below is brief description of the process of the interviews.

#### **3.5.2.1 Narration of life stories by 16 elite older Xhosa women**

The 16 women regarded as the elite group were interviewed in their own homes. While the initial plan was to conduct FGDs each made up of four elite older women, Sister A discouraged this methodology as she felt that these women were highly secretive and would not want to reveal their knowledge in front of others. The same protocol as in the primary sample regarding the format of the interview was followed (see interviewing guide in appendix C). The elite older Xhosa women were asked to:

- Narrate their life stories in terms of how they had learnt about IHK and ultimately became renowned for their ability to treat illnesses and ailments. The researcher facilitated the discussion and prompted them to speak about turning and pivotal points in their lives that further consolidated their knowledge.
- Use storytelling to relate critical incidents that they were asked to contain; one of which was a success and the other an unsuccessful encounter; including how they had managed to contain these incidents. The participants were reluctant to speak about these critical incidents.

#### **3.5.2.2 Individual interviews with family members of the primary sample**

The elite older Xhosa women were more open to their families being asked questions regarding how they managed health problems within the home situation. The researcher conducted individual interviews with:

- the daughter-in-law of one of the elite older Xhosa women (the researcher struggled to get hold of the second daughter-in-law, who apparently was not well)
- a granddaughter; and
- a grandson and a granddaughter.

Each family member was interviewed in their homes. Two main themes informed these interviews:

- Who is the person that is consulted when somebody falls ill in the family and for what ailments are they consulted?
- Why is this person usually consulted, that is, what attributes does this person which contribute to her/him being consulted? (see appendix C)

### **3.5.3 Ethical considerations**

Prior to conducting the FGDs, a consent form was verbally explained to them - as the majority were illiterate or had low levels of education. They verbally accepted the conditions of the consent form. The process of explaining ethical considerations was undertaken in all interviews. In the case of minors (the grandchildren) consent was obtained from either the parents or grandmother if the parents were not there.

The consent form explained:

- the aim of the research;
- the research process and the role of each participant;
- permission needed to write down and tape record the discussions;
- the principle of respecting anonymity by not putting individual names in the thesis and addressing participants as a group; also that participants could withdraw from the research process at any time;
- a community-based feedback workshop would be conducted prior to making the research public;
- the protection of intellectual property through acknowledgment of their contribution to the research study during academic presentations and publications and that information would not be utilised for personal gain (see Appendices A and B for English and Xhosa consent forms).

During the different layers of the research process and the interviews, the researcher would ask permission from participants to use the tape recorder to record interviews as well as to allow the research assistants to write notes that were documented in small, hardback notebooks.

### **3.5.4 Process of data collection**

The researcher was the main person who conducted the FGDs, and was assisted by two research assistants (social science student in the pilotstudy, later joined by a law student for the main study). The researcher first read the consent form guidelines to the women to gain agreement for conducting the study. After a full explanation of the study had been given, the women gave verbal consent to participate in the study. Tape recorders with sufficient batteries and small sized, hardback notebooks were used to document the FGDs. The

research team agreed that the researcher would facilitate the discussions. The research assistants would document the interviews. Their written documentation was augmented by the audio tape recordings. It was also agreed that whenever the research assistants picked up that there was an area that the researcher had omitted or that something in an area could be improved by way of further probing or asking things differently, she would time a space to move into the discussion and address the area. This would further enrich the data as the law student was from the study area and both she and the social science student were young Xhosa women who had grown up in a rural environment under the supervision of older Xhosa women.

The questions on the interview schedule (see Appendix C) related to each objective of the study and were posed to the older Xhosa women. They were given time to discuss issues with each other until they had exhausted the discussion and come to a conclusion. From this process the researcher was able to:

- contextualise perceptions and opinions;
- start to develop a plot to describe the full setting and character of the phenomenon under scrutiny (151);
- describe roles and responsibilities, that is, analyse the positions that people occupy and the behaviour associated with those positions, specifically, the positions of the older Xhosa women in the family hierarchy and the rationale for suggesting that they would be the first to be consulted when anyone had a health problem in the home (2);
- select the elite older Xhosa women for interviewing.

The research assistants manually transcribed the taped interviews word-for-word in Xhosa (this was their mother tongue and made it easy for them to document the information). The researcher transcribed these notes into English with the research assistants filling in the gaps where necessary. For the main study, it was agreed amongst the research team that data collection would start at 10:00 with a FGD, a break for lunch, and then one individual interview would be conducted, so as to finish at 15:00. They would then go back to the dwelling place for tea and start transcribing the data. For the main study, the research team collected data from Monday to Friday, with a rest on Saturdays and Sundays. The data collection days proceeded more or less along this pattern for a month.

### **3.5.5 Trustworthiness of data**

For this thesis trustworthiness of data covered the following areas: credibility, transferability, dependability and conformability. (155)

### **3.5.5.1 Credibility of data:**

*Prolonged engagement:* During the FGDs the researcher continued to gather data until saturation point was reached.

*Limit ones adverse effects on participants:* The researcher was aware and sensitive to the unequal position of power she holds against the participants during FGDs. The researcher was careful how she frames questions and avoided to leave the interviewee with yes or no choice of answers. The researcher also listened more and said less, thereby giving the platform to the older Xhosa women to find their voices and express themselves. (156)

*Member checking during FGD:* During the FGDs, the older Xhosa women would engage in discussion regarding a certain concept. They had a tendency to go round and round until they would all agree on each and every concept. On the other hand, when the researcher further observed this process, she discovered that there was an element of affirmation for each other, and with this affirmation, another new point would emerge, which would then again be subjected to the process of going round and round, affirming this new point and continuing until full agreement again had been achieved.

*Member checks to interpret initial findings:* This occurred after analysis of data where the participants were given the opportunity to engage with the interpretation of findings. This was done in the following manner: Six months after data collection, a feedback workshop was conducted for each FG to ensure validation of data, to fill in any gaps, and to share initial findings with the participants. Not all the women who were present for the first FGDs could attend the feedback workshops. Attendance was as follows:

- The FG that was held closest to the hospital, three of the attended.
- The FG that was held second closest to the hospital, four women attended.
- The FG that took place third farthest away from the hospital, six women (instead of the original 12) attended.
- The FG that was farthest away from the hospital, two women attended.
- Six elite older Xhosa women also validated the findings of this study during feedback workshops. The researcher read out to the women the list of health problems and the strategies including medications that were mentioned by the those from the four FGDs. The women affirmed these lists, but further cautioned the researcher of certain approaches and medications to certain health problems, as they felt such approaches were very aggressive. They had the impression that, lately, the immunity of the people had been very low and that, due to such conditions, the best approach was to take the person to the hospital.

*Link with qualitative experts:* In the final stage of data analysis, a skilled qualitative data analyst checked the agreement between themes.

*Triangulation:* This was achieved by using different samples to validate the main study findings. The process of triangulation explored the phenomenon of management strategies used by older people from different angles so as to gain more understanding and clarity, as well as why older Xhosa women were consulted when a family member was ill.

### **3.5.5.2 Transferability: thick description**

Extensive field notes were taken on the environment in which the study took place. These notes gave the researcher an opportunity to compare observations with the the researcher's original theoretical ideas and pick-up contradictions from the initial assumptions..

### **3.5.5.3 Dependability and conformability**

*Peer debriefing:* This assisted with the process of examining all documentation and processes, and acted as an auditing process. A qualitative researcher skilled in performing and analysing qualitative studies assisted with the review of raw data, data-reduction and data-analysis products, data-reconstruction and data-synthesis products, process notes and the researcher's daily journal. According to Babbie and Mouton (155), if the *auditing process* is managed adequately, it can be used to determine dependability and conformability.

## **3.6 DATA ANALYSIS**

This section provides an overview of the methods of data analysis used. These included data management and methods used for qualitative data analysis.

### **3.6.1 Data management**

The first part of the qualitative data analysis presents the data management for this study. Data management is as crucial as data analysis. In qualitative studies, large amounts of data come from a variety of sources, so it is important to build up a data framework that can be used throughout the study. The main issue when managing data pertains to ensuring "high-quality, accessible data, documentation". (1) During the early stages of data management for this doctoral thesis, the researcher personally managed the data. This comprised the documentation of the researcher's stories about the women who had made an impact on her own development, the interviews with the staff members of the hospital, the interviews during the exploration of community entry, and the development of community partnerships. Notebooks and tapes were kept locked in a cupboard in the researcher's office to which only the researcher had access.

For data collection during the pilot study, that is, the in-depth interviews with the five older women and one man from Buntingville, the researcher was assisted by a social science student. Here the researcher acted as the interviewer and the social science student acted as scribe. During the actual process of data collection (in the four FGs with 36 women and the 16 elite Xhosa women), the researcher managed the data with the help of two research assistants (the social science student in the pilot study, later joined by the law student for the main study). Here the researcher acted as the interviewer and the two research assistants as scribes. Storage of data for this phase followed a similar process to that of community entry and the pilot phase.

### **3.6.1.1 Formatting of data generated**

Three different types of texts were constructed to contain the data that was generated, namely, transcriptions, biographies, and a reflective process-driven writing approach.

*Transcriptions:* Each FGD and in-depth interview was transcribed to create a text that aimed at capturing the narrative discussion/conversation - i.e. all words, verbatim of the taped interviews. Prominent observations were incorporated into these texts.

*Biographies:* For the in-depth interviews with key informants and the elite Xhosa women, biographies were created and written down after the first interview. Biographies were further developed after subsequent interviews and during analysis.

*Reflective process-driven writing approach:* During the unfolding of the study it was important for the researcher to continually reflect on the process so as to be able to link events and pull through the golden thread connecting issues that ultimately would culminate into a plot regarding how the older Xhosa women manage health problems within their home situation. Hence, ideas, impressions, observations and questions that arose during the interviews/discussions were captured by the researcher as soon as practicable after interviews had taken place. These documents were further incorporated during the analysis and interpretation process.

### **3.6.2 Qualitative data analysis**

The data analysis comprised of an informal ongoing stage of data analysis within data management, as well as a formal stage of data analysis.

#### **3.6.2.1 Informal ongoing stage of data analysis within data management**

Data analysis is the process of bringing order, structure and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative and fascinating process, and does not proceed in linear fashion. Qualitative data analysis proceeds in search of

general statements about relationships amongst categories of data; through to ultimately bringing forward a grounded theory. (1,2,4)

Gold (157) maintains that in ethnographic research, rather than relying on a preconceived framework for gathering and analysing data, ethnographers use their interactions with informants to discover and create analytical frameworks for understanding and portraying that which is under study. Early in the research process of this doctoral thesis, the researcher developed an analytic strategy that meant ongoing analysis throughout the different stages of the study. Hence, observation strategies were adjusted, and the emphasis shifted, tested and re-tested to avoid bias. Categories that characterised the older Xhosa women's strategies for the management of health problems were identified. These categories, together with the selection of conceptually intriguing phrases from the audio-tapes, assisted in suggesting patterns. From these patterns, the researcher could start to draw up tables based on the key themes of the study objectives. From these further key themes started to emerge and the data started to develop its own direction.

### **3.6.2.2 Formal stage of data analysis**

During this process, the researcher tried to reflect on her own biases and tried to separate and draw boundaries on these before interpreting the data as to protect infecting the data with her assumptions. Transcriptions from the FGDs and the interviews were read and re-read until the researcher comprehended what the speakers were saying and was able to examine how individuals were experiencing the topic. From the text, a list of significant statements expressed by the participants was drawn up. These statements were grouped into 'natural meaning units'(151) expressed by the participants. (Meaning units are essentially those statements which are seen to elucidate the research phenomena.) These units of meaning were grouped together in areas of similarity and dissimilarity.

Each meaning unit contained a distinctive and unique idea. Once the meaning units were grouped, they were further analysed to discover specific similarities in meaning to form 'clusters of themes'. (4) Each category was developed into textual description, which elucidated what the older Xhosa women see as health and illness within the home situation. This included the determinants of health and illness, as well as strategies they use to manage the health problems. (2,4)

Categories were examined in conjunction with the raw data (from which the categories were derived), in terms of the specific purpose of the study. To clarify, the researcher needed to ask: What does this statement reveal about the research question? In the context of this

study, this related to how the older Xhosa women view health and illness, as well as how they managed health problems within the home situation.

While formulating categories from the meaning units using the transcribed responses, the researcher needed to identify only those units that pertained to the purpose of the study, namely, the IHK carried by the older Xhosa women for the management of health problems in their home situation. This process required a substantial amount of intuition and judgment on the part of the researcher. The categories were weighed against the research questions and subsequently further analysed and interrogated resulting in a process from which 'central themes were determined'. (151) These themes were extracted from all the categories emerging from participants' experiences. This allowed for common themes to unfold from the experiences of all participants pertaining to the phenomenon under scrutiny.

The final stage of analysis was *narrative analysis*. (151) This next and final step involved the grouping together of themes. The aim was to assemble the essential, non-redundant themes and to formulate a descriptive statement which captures the "essence of meaning units within the holistic context". (2) In this phase of analysis, the researcher incorporated all the themes extracted from the FGDs and the in-depth interviews into one summary. This process assisted in constructing biographies and could be understood as the 'second level' of analysis.

Biographies were constructed in such a way so as to foreground the life plots with regard to health, illness and the health problems that the older people managed within the home situation. These elucidated turning points for the older Xhosa women as managers of health problems within their home situation. Therefore, the development of themes was informed by categories that emerged during the first and second level of analysis. This put the data into an holistic context that essentially reconstructed the inner world of the participants' experiences.

The biographies presented certain events, actions and happenings pertaining to the healing practices of the older Xhosa women. Their engagement with health and illness was organised into plots, ranging from initial entry into IHK, to understanding what health and illness is, and the events that undermine health. These formed part of the narrative analysis.

According to Denzin (151), the ultimate goal of phenomenological research is to produce a research report that gives an accurate, clear and articulate description of an experience. The reader should come away feeling, "Now I understand better what it is like for someone to experience that".

### 3.7 CONCLUDING STATEMENT

The proposition made in the study design was that the older Xhosa women use IHK for the management of health problems in their home situation. The initial pilot of the methodology that was done in a rural village in the Eastern Province confirmed this proposition and what the study hoped to achieve by exploring IHK in older Xhosa women residing in the Eastern Province. The piloting process also gave the researcher confidence that the methodology to be used in the main study would help to achieve the primary and secondary objectives of the study as the older Xhosa women that were used for the pilot study did not only provide an understanding about IHK but wanted to know how this knowledge can be revived. They also added some suggestions during the discussion, such as the idea of reverting to *ndalalshe* (old traditions and values systems).

The response of the study sample during the collection of data re-assured the researcher of relevancy of doing an enquiry of this nature as like in the pilot study, they were able to respond sufficiently to the objectives of this study. It further affirmed the assumptions that were made in Chapter 1 about the management of health problems by the older Xhosa women using IHK.

Limitations regarding the methodology is discussed at the end of Chapter 5 .

## CHAPTER 4: PRESENTATION OF FINDINGS

### 4.1 INTRODUCTION

This study explored and described the IHK carried and used by older Xhosa women in the management of health problems in their home situation, with the aim of recommending to key stakeholders that these women and their health knowledge and skills be validated and used as the first port-of-call for ailments in the home. To achieve the objectives of the study, 36 older Xhosa women, drawn from villages in the rural Eastern Cape province, were consciously selected and voluntarily participated in four different FGDs (the primary sample). The secondary sample comprised 16 elite older Xhosa women and their family members. Their information validated the findings from the primary sample.

### 4.2 DESCRIPTION OF HOW THE FINDINGS ARE PRESENTED

The findings of this doctoral study will be presented in the order shown in the chart below.

**Table 4.1: Framework for presentation of findings**

Section	Description of each section
<b>4.3 Presentation of findings - Section 1:</b> Primary sample (36 older Xhosa women)	4.3.1 Demographic details of participants 4.3.2 Definitions of health and illness 4.3.3 The health problems that older Xhosa women manage at home 4.3.4 Critical incidents from the four FGDs 4.3.5 Perceptions of the older Xhosa women with regard to why they are consulted by their families when a family member is ill
<b>4.4 Presentation of findings – Section 2:</b> Secondary samples	4.4.1 In-depth interviews with the elite group of older Xhosa women 4.4.2 In-depth interviews with family members of the elite older Xhosa women
4.5 Presentation of findings – Section 3	4.5.1 Transitional conversations with the members of Gusi village

### 4.3 PRESENTATION OF FINDINGS: SECTION 1: PRIMARY SAMPLE

The primary sample consisted of 36 older Xhosa women.

#### 4.3.1 Demographic details

It was difficult for the researcher to collect demographic details according to the prescriptive manner in which she had been trained, and it became clear that this study required a different approach, including storytelling, in order to obtain complete information about each of the FG participants. Since it appeared that the majority of the women had not been to school, collecting specific details was even more of a challenge. Nevertheless, the researcher found that listening closely to the older Xhosa women tell her about themselves revealed some interesting information. It was important to note that none of the women had married into their own clan, and that the majority had been born in villages outside of Gusi. They had only come to Gusi in order to get married.

The majority of the women were widows at the time of the FGDs. In FG 3, four out of 12 husbands had passed away (34%); in FG 1, only three out of ten husbands were still alive; in FG 4, only one husband was still alive; and the women in FG 2 did not reveal whether their husbands were alive or dead (although they were asked). The Chief was over 80 years old. Two of the 36 women's children had been born with congenital impairments. It appeared that the Gusi families were large, as, on average, the women had seven children. For all, diarrhoea-related diseases among the infants/children had been a problem. Table 4.2 presents more demographic details about the primary sample.

**Table 4.2: Demographic details of the primary sample (36 older Xhosa women)**

Focus Group (FG)	Number in each FG	Husband alive	No. of children	Loss of children/average per household	Cause of death
FG 1	10	3	50	24/2.4	Diarrhoea
FG 2	8	-	47	21/2.5	Diarrhoea
FG 3	12	8	89	30/2.6	Diarrhoea
FG 4	6	1	38	11/3	Diarrhoea

#### 4.3.2 Definitions of health and illness

Participants were asked to define their understanding of health and illness, specifically: (a) What do they understand by health, and what are the determinants of health? (b) What do they understand by illness, and what are the determinants of illness? Their narratives in the FGDs about health and illness were then organised into codes, which were assembled into categories, which were finally categorised into four main themes:

- perceptions of health;
- determinants of health;
- perceptions of illness; and
- determinants of illness.

Categories and codes were aligned within these four themes for all four FGs.

#### **4.3.2.1 Focus Group 1: Definitions of health and illness**

Some participants in FG 1 saw health as being the absence of disease, as well as the presence of happiness and wellness. Others saw health from a negative perspective, as being the absence of health and the presence of disease and pain. Giving birth, especially to healthy children, was seen as a good contributor to health.

Food was also seen as a contributor to health, and was described as the 'health of the home', on which one older woman expanded as follows:

*Children are not working; they plant the fields. Health is to plant plants. Cabbage, potatoes, that is the health of the home.*

Determinants of health were seen from a negative perspective. For example, women described worry as a strong determinant of ill-health, and men were seen as contributing negatively to health. Troublesome children - *you can die from this* - were negative, as opposed to children who treat you well, who were deemed to be a positive contribution to health. Illness was seen as the presence of body pains and as flesh not functioning well. A sore heart was seen as a contributor to illness.

Table 4.3 presents FG 1's categories and codes for these themes.

**Table 4.3: Summary of Focus Group 1's definition of health and illness**

<b>Themes</b>	<b>Categories</b>	<b>Codes</b>
Perceptions of health	Absence of disease, presence of happiness and wellness	<i>Absence of body pains and being happy; Health is to stay well; I am well, there is nothing wrong with me; Nothing is troubling me.  It is about illness or wellness; Health is not present; health is what we are complaining about; My knees are painful and I have body pains; My legs are painful, my waist is painful and urine is difficult to get out; Only the legs are getting tired.</i>
	Giving birth and having healthy children	<i>Having given birth; Health is present, because children are well; Minor body aches are not important, as long as the children are well; If children are well, then everything is fine.</i>
	Food a key contributor of health in the home	<i>The availability of food; Health is to plant plants, cabbage and potatoes; Food creates health and absence of poverty.</i>
Determinants of health	Presence of worry	<i>Worrying has a negative impact on health; You wake up with your pillow wet.</i>
	Being troubled by men	<i>There is not a single man that is not troublesome, but because you have children you have to stay in the household; The man will make sure that you quickly conceive, so that you can stay; You can never go when you have children; You have to raise your children.</i>
	Being troubled by children Presence of wellness	<i>You can die from troublesome children. It is being healthy; For you to be healthy, you have to be handled well, the children should look after you well.</i>
Perceptions of illness	Presence of body pains	<i>When you have pain; Pain in the body that makes you ill; When you have stomach-ache you cannot sleep.</i>
	The flesh that is not functioning well	<i>When something is happening in the flesh that causes illness.</i>
	Interpreted from within an emotional context	<i>Even a sore heart.</i>
Determinants of illness	Absence of money	<i>Not being paid undermines health; Not receiving old age pension.</i>
	Children that are not doing well	<i>If a child is lying down, if the children are not well, then health goes away.</i>

#### **4.3.2.2 Focus Group 2: Definitions of health and illness**

FG 2 viewed health as being very important, saying that one could not progress without health. They commented that they would be foolish not to take their health seriously, and instead to take the name of God. They saw the home as an entry to health, as was stated by one participant:

*We would also like to say it is true that first help comes from home - you always test again what you know, for example, umhlonyane. We were always afraid to use these things.*

FG 2 participants defined health from a negative perspective - as being in a bad state - and noted that there were many diseases, as confirmed by this participant:

*There is poor health, we are dying, I do not know why health is bad. I have a sore back. There are many diseases. Alcoholism, smoking and dagga, many things like AIDS, as a result of sleeping together.*

The absence of clean water and a proper sewerage system were seen as problematic and as bringing disease, as noted by these participants:

*There are no toilets.*

*There is a lack of drinking water.*

*We drink with cattle and horses, and there is no electricity.*

Participants spoke about the lack of work and poverty that bring ill-health:

*We are struggling, hungry. There is poverty, no work. There are no projects. People are not sure when projects start. People are not motivated and those that lead disappear; all these cause ill health.*

Others interpreted the lack of food in their homes as being a drought in their household.

This group regarded illness as 'a soul that is not doing well', which, for them, was worse than body pains. They acknowledged that they could not depend on the government and that they could not revert to the way that things used to be. Participants acknowledged that they could not revert to their previous state, and that obviously the only way was forward, and that, as they moved forward, they could not depend on the government in order to survive - they claimed that the government was a new system in their lives, and that they felt that they needed to go back and to look at the importance of the home.

**Table 4.4: Summary of Focus Group 2's definition of health and illness**

<b>Themes</b>	<b>Categories</b>	<b>Codes</b>
Perceptions of health	Importance of health	<i>Health is very important; You cannot progress without health; Health is very necessary and is of a great variety.</i>
	Absence of health and presence of disease	<i>Ill health; My back is painful; Body pains, knees and voice are painful; There is poor health; We are dying; Health is in bad shape, health is in a bad situation; Wife is seeing the doctor because of body pains; Anxiety, alcoholism, smoking, drugs and dagga, many things like AIDS; There are many diseases.</i>
	Absence of work and presence of struggle	<i>Absence of work and presence of struggle; No project - people are not sure when the project is starting and not motivated. I have drought and poverty in my household.</i>
	Absence of household amenities	<i>No toilets, nor water; We drink water with the cows, cattle and horses (5); No electricity (2); No toilets.</i>
	Absence of food	<i>No cabbage, people try, but it is dry; Not to eat everything, hunger, water; I do not eat well in my household.</i>
	Presence of peace and healthy pregnancies	<i>I want peace and may what you carry be well.</i>
Determinants of health	From this group it was difficult to pin down what they saw as the determinants of health.	
Perception of illness	Unhappy spirit	<i>Spirit that is not doing well, more than body pains; Having somebody ill is worse.</i>
	Presence of disease and death	<i>Body pains, anxiety, death.</i>
Determinants of illness	From this group it was difficult to pin down what they saw as the determinants of sickness.	

#### **4.3.2.3 Focus Group 3: Definitions of health and illness**

For FG 3, wellness, happiness and the production of food seemed to contribute positively to health, which was affirmed as follows:

*It is to stay well in your household. Being happy. Ploughing everything - mealies in the ground, people eating maize. Reaching satiety - fullness, nourished. Eating and being happy.*

Peace, happiness and looking after all the children of the village, with the woman being the mediator of this peace, was regarded as an important contributor to health, demonstrated as follows from what the FGD had to say in this respect:

*Health is to stay well; Health is to stay in my house with my children. And to be happy; Where there is respect for each other - from young too old and vice versa, no conflict. To work with one spirit, assisting each other. If there is no peace, then this affects health. So there is a need for peace - this undermines health, especially that of the parent in the household. As a woman, you are looking after the household of the Mathiles (this relates to the family (into which) you have been married ... ). You do not only look after your own children alone; It is to stay well in your house, (to) be happy in your house and (to) be free; Health is happiness within the household, and sharing in the village, and being generous, and knowing children from the village, and taking them as your own; It is to stay well with minimal conflict amongst (the) children.*

The FG explained happiness in the following way:

*It is happiness and satisfaction within the heart. No conflicts or mishaps. It is happiness within the body; Happiness is staying in (at) good peace with the children; What comes first is having God; Well-being is a good living, and then happiness follows.*

According to this FG, there are many ways in which to see illness:

*There are many approaches and thoughts about this and pain; they are not the same; Death in the family causes the blood to be disturbed, and this can cause ill health; Health is disturbed by children who leave and go to work in cities; this brings ill health; You do not get tired of somebody.*

The lack of food production and the need to depend on money to buy food were seen as some of the determinants of illness:

*Now people do not grow plants or mealies, everything is bought; You educate children and they leave after qualifying, that brings ill health; Before, in Gusi they used to plough; This whole thing of not ploughing - food is bought - causes problems, as we depend on pension. And this pension does not solve problems; instead, it causes unhappiness, as it gets finished before you have solved your problems and found happiness, and staying well goes out of the window as money gets finished in the middle; But this is no longer happening. Now we wait for the pension to buy things. But this also causes stress, as we have a lot of debt, and we*

*go into a vicious cycle, as we buy shoes for (our) grandchildren, and have to pay school fees.*

Outsiders who came to the area with modern ways of planting were seen as having had a negative impact on the old ways of ploughing and food production, which impacted negatively on health:

*We were messed up by trust, and there was disease that killed our cattle. During Matanzima's time we had tractors and these were taken away - lack of sustainability; There are no children to plough the fields, as the children have gone to school; There is no fencing, and children do not look properly after the cattle and sheep; There were tractors and cattle; Children wake up early in the morning to bring up water. This causes ill health.*

The participants in this FG saw health as having many layers that linked both the physical and the spiritual:

*You tell people of your ill health from a superficial perspective, as people tend to laugh at you. You tell people about the physical, and leave the ill health of the soul. You do not say everything out loud, only talk of body pains.*

For the FG members, health appeared to be hanging in the balance, and children appeared to be the main determinants of health and illness:

*The health that we live is for the children now. They are uncontrollable now. In the olden days, there was good health as a person - even if a person did not have a child - they could ask any child and send them. Even children who do not go to school, they do not look after the cattle and sheep.*

There appeared to be conflict between the old and modern methods of raising children:

*What has brought about the whole problem is that they have been told that this is their time. The present time is wrong; the children are told that this is their time now and the future is theirs. Children of today twist messages for their own gain. What differs is that the children of those days were uneducated, and they feared their parents and the school. But children of today have outpaced the parents. Children of today will put up a case. Once you beat the child, you become a number in gaol. The children are unruly. Children talk back to the grandparents. Children of today do not apologise. They do not have peace. Education has taken away discipline.*

*Children belonged to everybody, even the person who did not have a child. The switch must come back. There is no child without a foundation. They need*

*discipline. Children are disciplined when they are young. Even in the olden days, children were not attentive.*

According to this FG, in days gone by:

*Children respected traditions, and could be asked from school to go and help make Xhosa beer. In our days, you cannot even hit your child, as you will be taken to gaol. As parents, we were uneducated, but children were satisfied with information from the parents. They used to get satisfied. A peaceful child is by luck, and is a gift from God, as today they do not listen.*

**Table 4.5: Summary of Focus Group 3's definition of health and illness**

<b>Themes</b>	<b>Categories</b>	<b>Codes</b>
Perceptions of health	Children as the focus of the home and village, and as belonging to all	<i>To stay well in your household, with my children; Stay with the same children working; Taking care of children from your village as a woman, not only your own children; Know the children from the village.</i>
	Production of sufficient food	<i>Ploughing everything, maize in the ground; People eating maize, eating and being happy; Reaching satiety, fullness and nourishment.</i>
	Peace, respect for all and happiness	<i>There is respect for each other from young to old and vice versa; No conflict between family and child. Being happy and free; Presence of peace.</i>
	Assisting each other and sharing	<i>Assisting each other; Working with one spirit; Sharing in the village and being generous.</i>
	Health seen as an individual issue	<i>It is the responsibility of each individual person to look after their health.</i>
Determinants of health	Happiness	<i>Key to health is happiness: First, you must have God, well-being and a good living, then happiness follows. To have happiness, you must have wellness. To have wellness you must stay in good health, be at peace with the children, have satisfaction within the heart, no conflicts or mishaps, happiness within your body.</i>

	Wellness	<i>Wellness is: when body pains have gone down. In the Xhosa tradition, you wake up, dress and work - this means you are well.</i>
Perception of illness	Migration of children to work in cities	<i>Educating children, then they leave after qualifying; Children who go to live and work in cities, this brings illness.</i>
	Lack of human resources to produce food	<i>No children to plough fields, not growing plants, Buying food, begging for food.</i>
	Presence of illness	<i>Live by the injection; A sick person also makes the family sick.</i>
	Heart not doing well	<i>Healthy bodies; Heart not doing well, develop disease such as high blood pressure.</i>
	Absence of money	<i>Debt, money causes stress; Get into debt to buy grandchildren shoes; Depending on money does not solve problems; If you get money, debt finishes money; as money gets finished, happiness, which is the key determinant of health, goes out of the window. Problems are not fully solved with money.</i>
	Absence of peace	<i>Absence of peace.</i>
Determinants of illness	Lack of energy	<i>Lack of energy; Lack of energy, even if you do not have illness.</i>
	A sick mother or a sick child	<i>A sick mother or a sick child; As a mother, if your child is not feeling well, you also do not feel well; If a mother is not feeling well, everybody is not feeling well.</i>
	A sick member of the family makes everybody sick	<i>A sick member of the family; If they are careless about health and they become sick everybody becomes sick; A sick person also makes the family sick.</i>
	Death, pain and an unrestful spirit	<i>Death, pain and an unrestful spirit; Illness is also about having a pain, and also about having an unrestful, unhappy spirit; Death in the family causes the blood to be disturbed, and this can cause ill health.</i>

#### **4.3.2.4 Focus Group 4: Definitions of health and illness**

FG 4 emphasised the importance of good welfare, as expressed in their discussion:

*When your welfare is good all over, where there is no confusion and fighting and you are happy. Health is to have no problems. When there is nothing that is harming you, there is no fighting and noise, nor hunger.*

They saw being a mother to healthy children that are well fed as contributing to good health:

*When you are a mother, you are well if you always have food to feed the children. The children are not ill; when children are ill, you are also ill. When you are mistreated at home. you become ill.*

Not having children was seen as part of being ill, as one participant explained:

*When you do not have a child you get thin a lot. Mrs S. never had children; although the condition of her uterus did allow for her to fall pregnant, the child died. Her health had deteriorated. She seemed to be somewhat emaciated. *There would be health if I had a child to think of.* Her husband was dead. She had a perception that: *My husband was the sun. When he is late, there is nobody to affirm me. Even when a tsotsi (a robbing person) wants money.**

Illness was seen to be about having a painful body, stomach-aches, AIDS, and painful bones. Drinking liquor was seen as contributing to illness:

*Umtshave alale, jakunyisa (a deadly alcohol that has replaced Xhosa beer and that has had bad health outcomes drunken by the women).*

There were also concerns about children dying from HIV/ AIDS. They said:

*When your children are ill, you also die from inside.*

**Table 4.6: Summary of Focus Group 4's definitions of health and illness**

<b>Themes</b>	<b>Categories</b>	<b>Codes</b>
Perceptions of health	Absence of illness and good welfare	<i>When you are not ill; When your welfare is good all over.</i>
	Being pregnant and being a mother	<i>Health is when you get pregnant and give birth well; You are happy - when you are a mother.</i>
	Peace and no fighting	<i>Where there is no confusion and fighting; Health is to have no problems; When there is nothing harming you; No fighting, noise; Mistreatment in the home can make one ill.</i>
	No hunger and having food for the children	<i>Always having food to feed the children; No hunger.</i>
	Healthy children	<i>The children are not ill; When children are ill, you are ill.</i>
Determinants of health	Food production	<i>Food production, nutrition, ploughing.</i>
	Producing your own liquor	<i>Making of Xhosa beer, this is better and takes long to prepare - four days.</i>
	Being well	<i>Wellness is: when you are a mother you are well, if you always have food to feed the children.</i>
Perception of illness	Presence of disease and pain	<i>Illness is about a painful body, stomach-ache, HIV and AIDS, and painful bones.</i>
	Death	<i>Children are dying, and we are dying.</i>
	Ill children	<i>When your children are ill, you also die from inside.</i>
Determinants of illness	Being lonely and not having somebody to affirm you	<i>Having dead husbands and being left without somebody to affirm them; When you do not have a child, you get thin.</i>
	Absence of peace in the home	<i>A mother-in-law and a daughter-in-law that are in conflict; Diseases enter when there is no peace.</i>
	Being modernised	<i>Having taken the forward movement that has landed people in deep trouble; Their time being over; The world that is broken.</i>
	Migration of second generation to cities	<i>Children and daughters-in-law leaving for the city.</i>

To stop ploughing and to buy food from the shops	<i>Absence of maize; The mealie-meal makes you constipated even if you take diuretics; People do not buy nutrition.</i>
Buying of alcohol	<i>Instead they buy alcohol - there is alcoholism; Buying of liquor.</i>
Children drinking and smoking	<i>Children that are smoking and drinking.</i>
Having stopped making Xhosa beer	<i>Stopping making Xhosa beer.</i>

#### **4.3.2.5 Combined categories from the four focus groups to develop sub-themes**

The categories arising from the four FG discussions were combined to develop the emerging sub-themes, as can be seen in Table 4.7 below.

**Table 4.7: Combined categories from the four focus groups**

<b>Themes</b>	<b>Subthemes</b>	<b>Categories</b>
Perceptions of health	Health is important and an individual issue	<i>Health is important; Health (is) seen as an individual issue.</i>
	Health described in terms of the absence or presence of disease	<i>Absence of disease; Absence of illness; Absence of health and presence of illness.</i>
	Healthy pregnancy and healthy children are the key determinants of health	<i>Being pregnant and healthy, being a mother; Giving birth, and having healthy children (3); Children being the focus of the home and village, and belonging to all.</i>
	Food a key contributor of health to the home.	<i>No hunger and having food for the children; Production of sufficient food; Absence of household items such as absence of food.</i>
	Presence of peace, happiness, wellness and support for each other.	<i>Presence of peace (4); Peace and no fighting; Respect for all and presence of happiness (2); Wellness and good welfare; Assisting each other and sharing.</i>
Determinants of health	Positive determinants	<i>Happiness and wellness (4); Having God; food production and producing your own liquor.</i>
	Negative determinants	<i>Presence of worry; Being troubled by a man; Being troubled by children.</i>

Perception of illness	Interpreted within physical perspective	<i>Presence of illness; Presence of body pains (3); Presence of disease (3); The flesh that is not functioning well and death (2).</i>
	Interpreted within an emotional context	<i>Unhappy spirit; Heart not doing well; Absence of peace; ill children.</i>
	Migration of children to work in cities	<i>Lack of manpower to produce food.</i>
	Absence of money	<i>Absence of money (2).</i>
Determinants of illness	Body not doing well	<i>Pain, lack of energy and death.</i>
	Spirit not doing well	<i>Unrestful spirit; Absence of peace in the home.</i>
	Children not doing well; mother not doing well; family member not doing well	<i>Children that are not doing well; A ill mother or a ill child; A ill member of the family.</i>
	Absence of work	<i>Absence of work and presence of struggle.</i>
	Loneliness	<i>Being lonely and not having somebody to affirm you.</i>
	Migration of children to the cities	<i>Being modernised; Migration of second generation to cities.</i>
	Unable to produce food and Xhosa beer	<i>To stop ploughing and buy food from the shops; Having stopped making Xhosa beer; Buying of alcohol.</i>
	Substance abuse by children	<i>Children drinking and smoking.</i>

**Table 4.8: Themes and sub-themes on definitions of health and illness from the four Focus Groups**

Themes	Sub-themes
Perceptions of health	Health is important and an individual issue. Health described within the absence or presence of disease. Healthy pregnancy and healthy children are the key determinants of health. Food a key contributor of health in the home. Presence of peace, happiness, wellness and support for each other.
Determinants of health	<i>Positive determinants:</i> Happiness and wellness; Having God; Food production and producing your own liquor. <i>Negative determinants:</i> Presence of worry; Being troubled by a man; Being troubled by children.
Perception of illness	Interpreted within physical perspective Interpreted within an emotional context Migration of children to work in cities. Absence of money.
Determinants of illness	Body not doing well. Spirit not doing well. Children not doing well. Mother not doing well. Family member not doing well. Absence of work. Loneliness. Migration of children to the cities. Unable to produce food and Xhosa beer. Unable to link with ancestors. Substance abuse by children (smoking and drinking).

The older Xhosa women presented the definition of health and illness from a broad perspective of wellness that links the body, the spirit and the mind. Children appear to feature strongly in the health definition. Their ways of disciplining children appear to be in contradiction with the government of the day, which sets a cycle of confusion and fear regarding the possibility that they might slip back into the old ways of disciplining children, entailing the use of corporal punishment, that could result in them going to gaol if the children continue to be unruly. The above establishes a vicious cycle of worry that is a poor determinant of health. Production of food was seen to be at its lowest by these women, with them continuously experiencing hunger, which undermined the possibility of brewing Xhosa beer that would otherwise have created a space in which they could link to their ancestors and give them reverence. In terms of the modern approaches of conducting projects and installing running water and toilets, they were still left in need, as the government of the day

appeared, at the time of the study, to be slow in supplying such amenities. Hence, the best approach for the older Xhosa women was for them to return home, where all their skills of managing health might have started to get lost.

#### **4.3.3 The health problems that older Xhosa women manage at home**

Participants in the FGs were guided to provide input into the health problems that older Xhosa women manage at home (see interviewing schedule appendix C). Below is a presentation of the results from each FGD.

##### **4.3.3.1 Focus Group 1: The health problems that older Xhosa women manage at home**

This FG was situated close to the hospital. When asked to define what they understood by the concept of 'health', they initially appeared to do so from a deficit perspective. However, they gave contradictory responses when they were asked which illnesses they managed at home - they identified similar illnesses to those that they said should be managed by the hospital. As one participant explained:

*There is chest pain of the home on the left-hand side. The chest pain caused by TB can only be helped in the hospital. With the one of the home, the people of your house must talk to the ancestors to try to gain an understanding of what they are trying to say.*

The above participant stated further:

*Regarding headache, there is headache of the home, and there is one that is dealt with at the hospital.*

Some illnesses appear to be beyond home care:

*When somebody has sent something to you (i.e. evil spirit) one must go to the traditional healers. The traditional healer prepares his things.*

Others felt strongly that:

*We have let go of the traditional healers. We first go to the hospital and the doctors.*

When referring to 'the doctors', respondents meant private doctors, and not the doctors in attendance at public hospitals. When asked why they did not consult the latter, one respondent explained:

*We no longer get injections at the hospital; we only get Panado. I go to the hospital, and I am given pills. And when this does not work, you give up and use traditional medicine.*

According to said respondents, there are three separate health systems - the hospital; the private doctors; and the traditional healers. The health outcomes of each were compared and evaluated by the respondents. As the above respondent expanded on what they had previously said:

*But this also does not help, you throw away these medications and go back to Dutch; Dutch is better. Or you go to the Dutch - this is the hospital. If you cannot be helped, you go to the doctor. You go to Umtata, and from there you are referred to East London. Even at night when you are ill you go to the hospital. If you cannot walk, you are carried in the wheelbarrow.*

(The hospital is sometimes called 'the Dutch', as it was initially built by Ministers of the Dutch Reformed Church.)

Despite this division in the choice of health care providers, the participants in this group all agreed:

*The day the hospital came is the day when everybody became well.*

One respondent lamented:

*I think all my children would be alive if the hospital was (had been) here when I gave birth to them.*

**Table 4.9: The health problems that older Xhosa women from Focus Group 1 manage at home**

Health problem	Steps to diagnosis	Management steps/strategies	Remedies	Rationale for relinquishing	Referral source
1. Chest pain 'of the home'	Pain on the left side of the chest.	Go home.	Slaughter an animal; talk to the spirits; try to understand what they are saying.	Pain getting worse.	Traditional healers
2. Chest pain caused by TB	Observation: Dyspnoea increases with walking - coughing up blood.	Can only be helped at the hospital.	Medication from the hospital.	Once diagnosis has been established.	Hospital
3. Headache 'of the home'	Somebody has sent an evil spirit to them.	Visit the traditional healer.	The traditional healer prepares a concoction.	Initially visit traditional healer.	Traditional healer

4. Headache 'of the hospital'	Observation.	Visit the hospital.	Medication from the hospital.	Diagnose it as a 'headache of the hospital'.	Hospital
5. Eye discharge	Weeping eyes	Initially home, then hospital/or Dutch	Squeeze a herb into your eyes / take pills given at the hospital.	If you cannot be helped - you are only given pill, not injection.	You visit the doctor even at night - if you cannot walk, you are carried in a wheelbarrow.

From Table 4.9, it is evident that participants mentioned three main health problems - chest pains, headaches and eye discharge. Two of the conditions were classified as belonging to the category of home management. The above creates the impression that participants were delineating the conditions as belonging to the home, in case somebody started challenging them on why they were managing the conditions at home, as it appears that they had a perception that all illnesses must be managed by the hospital. This group appeared to have little understanding of conditions that could be managed both at home and at the hospital (five conditions were mentioned). On follow-up at the feedback workshop (see report on feedback workshops in Appendix F), said participants gave the same response, namely that they preferred to take their relatives to the hospital when they were ill. When they were asked why they had initially responded that it was the hospital that had brought about all their illnesses, they said that, in that case, the hospital should take care of all their illnesses.

#### **4.3.3.2 Focus Group 2: The health problems that older Xhosa women manage at home**

This group lived slightly farther away from the hospital. Although they initially mentioned that there were some illnesses that they managed at home, they were reluctant to identify which illnesses they were. The following statements confirm this:

*We appreciate that you came to ask us about these things and we would also like to say it is true that first help comes from home; you always test against what you know, e.g. umhlonyane (a medication used for coughs and flu).*

They explained:

*We were always afraid to use these things. We cannot go back to how things were. Living those days was difficult. People used cows for ploughing fields. We were fooled.*

Regarding diseases, they explained:

*There are many diseases. Alcoholism, smoking and dagga (taking), (and) many things like AIDS, as a result of sleeping together.*

They felt that said conditions were, and should be, managed at Madwaleni Hospital. However, they complained about not having projects (work) and required the intervention of the government, as the extract below shows:

*There are no projects. People are not sure when projects start. People are not motivated, and those that lead disappear. We are also waiting for the government.*

This session was closed with them lamenting:

*There is poor health. We are dying. We need an ambulance.*

No table is given summarising the health problems that the participants in this group stated that they managed at home, as they said that all illnesses were managed by Madwaleni Hospital.

#### **4.3.3.3 Focus Group 3: The health problems that older Xhosa women manage at home**

The older Xhosa women from this group contributed extensively to the discussion. They were happy to be asked about the extent of their knowledge, and about how they managed health problems at home. One of the participants said:

*Here within the Mbovane tribe – this is where you get medication. This is where you can get ityholo and impepho; this is where you can get green things (herbs).*

They also believed that the response of the person to their medication and healing depended on the person's immunity, as one participant expanded:

*Healing is related to how the blood of a person is; in terms of getting better, all illnesses are related to how the blood of the person is, even wounds.*

Participants were aware of certain common conditions in their village, and had strategies for diagnosing them:

*Coughing non-stop, TB, is a special one. You do not stop, and you start coughing out bloody sputum, or, ultimately, blood. TB was always there, but it was not this common. Cough by cold is cured at home.*

Respondents speculated about the increase of TB being related to the high prevalence of HIV/AIDS in Gusi. They also considered childhood illnesses as sometimes being related to the mother's bodily response to the external environment:

*Isisu samalaza is related to a child who drinks breast milk after you have been away for a while and the first milk has to be taken out before you feed the child. If you have taken a journey where two roads meet, you bring the grass from the*

*intersection. You must bring grass from your journey, then you pour water and grass together and wash the child with that water. This helps to prevent or cure amalaza.*

Whereas:

*When a child is born, you boil water and isichakathi and feed the child, and the aim is to get rid of ijengezi (i.e. black first stool). Isikhikhi is put in a bottle and you give it to the child to prevent ishimnca (i.e. a rash that babies usually develop) - you can mix this with umthombothi. Ingxozela is a type of tree; you smear the sap of ingxozela on the child around the umbilicus cord before it is lost to stimulate its loss and healing.*

They are also aware of their own limitations:

*Ukuxhuzula (i.e. seizures) are difficult to diagnose while a child is very young.*

They also believe that biomedicine has caused them to forget about their knowledge:

*When the clinic is in your head, you forget about all these things.*

They expressed their belief that looking after the health of the family is the joint responsibility of the mother and father of the family:

*First, in a household without a father, the main person is the mother. In a household where there is also a father they help each other. When they cannot handle the child at home at all, they go to see the doctor, clinic or hospital, or Uye nakukhohlela esingeni (i.e. indigenous healers).*

Observation plays a big role in their diagnosis, as this extract shows in relation to the diagnosing of a child as being ill:

*When a child is ill, a child will not play. If you throw the child up, the child cries. It can start early with you as a parent, feeling that your breasts are tingling. The child will not play and cries; maybe the child is teething. Then you pick up a medicine that has laxative effects to relieve tension in the stomach and to decrease temperature. The mother of the child must report to the grandmother/mother-in-law. If the grandmother/mother-in-law cannot help then you take the child to the khohlela esingeni or doctor. When a household has been defeated, it is either a private doctor or khohlela esingeni who can help. But (the)\_hospital is number one.*

**Table 4.10: The health problems that older Xhosa women from Focus Group 3 manage at home**

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
1. <i>Ikrwede</i> (caused by a tapeworm)	Vomiting and stomach cramps.	<i>Mafumbuka</i>	Grind raw; mix with water. Give 2 tablespoons, 3 times a day.	Uncontrolled diarrhoea.	Afraid of dehydration and losing energy.	Hospital - elite person.
2. <i>Makrokro</i> (bloody stools)	Diarrhoea with blood - try unsuccessfully to pass a stool.	<i>Mafumbuka</i> and sea-water	Mix with sea-water. (This method is rejected by elite women. According to them, sea-water is corrosive and will increase the diarrhoea.)	Stomach, feet and hands start to swell, and diarrhoea does not stop.	Fear of dehydration and losing energy.	Hospital - elite person.
3. <i>Isisu sokuntshintsha</i> (period pains)	Sometimes accompanied by period stains (droplets of blood coming out).	Conservative; sometimes take to special person; when cured, one can conceive.	If given medication ( <i>Misela</i> ), danger of conceiving. Treat conservatively.	No critical incident, except danger of not conceiving if not treated.	Continuous period pains that might decrease the chances of conceiving.	Take to an elite woman, or to a traditional healer.
4. <i>Isisu samalaza</i> (stomach-ache in a child, caused by mother being away from home)	Diarrhoea with sour, milk-like stool.	Grass and dust from the intersection or <i>Ubuhlungu</i> .	Bring grass from the intersection. Wash child with water that has been rinsed in this grass.	Usually helps.	No need to give up.	No need to refer.
5. <i>Ijengezi</i> (first stool)	First black stool - all babies need to get rid of this stool.	<i>Isichakathi</i>	Boil in water and feed to child.	Dangerous if stool does not get out; can cause 'plate', or can go up the back and cause damage.	Problems in child's development - 'plate'.	Visit coloured person who knows about this type of medication
6 <i>Ishimnca</i> (rash in children after birth)	First rash after birth.	<i>Usikhikhi</i> , <i>Ingxozela</i> , <i>Umthobhothi</i> .	Boil <i>sikhikhi</i> with water, cool and drink. Use leaves to make paste and smear on the	Usually clears up - can cause ear problems.	Dealt with successfully at home.	Unnecessary.

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
			child. <i>Ngxozela</i> - grind and smear. <i>Umthobhothi</i> - grind and smear. or mix with water and give a teaspoon of substance to child.			
7. <i>Intloko ehamba nesiyenzi</i> (headache and dizziness)	Flu or cold, uterus or bile.	<i>Isampontsha - ne impepho, ityholo.</i>	Boil it in water and inhale - use as snuff.	Headache persists for two days. Elite person says you should not use <i>sampotshane</i> and <i>tyholo</i> , as these are very strong.	Affects blood pressure.	Hospital .
8. Rash on the head	Fine rash.	Pig fat and <i>tsasela</i> .	Grind <i>tsasela</i> mix with pig fat, and smear onto affected area.	Approach usually helps. No complications.	Dealt with at home.	Unnecessary.
9. Stomach ulcer	Pain in the stomach, especially after eating certain foodstuffs.	Pumpkin seeds.	If mild, eat pumpkin seeds. Stay away from acidic and hard foodstuffs.	Depends on severity - can become severe.	Becomes severe.	Hospital antacid medication and diet regime.
10. Chest pain	Stabbing pain in the chest.	Talking to ancestors; placing of rope around a goat's neck; slaughtering of a goat and cow; and <i>thonjiswa</i> ritual.	Go home and speak to the ancestors. Make a rope, and place it around the neck of a goat and slaughter it; next a cow; and lastly <i>thonjiswa</i> , if it is a girl.	Incremental steps, related to pain not subsiding and contained with home-based rituals.	Incremental steps taken, according to severity of complaint.	Dealt with at home, in incremental steps.
11. TB	Coughing non-stop.	Visit the hospital.	Visit the hospital.	Progresses to cough; blood in sputum.	Progression of symptoms.	Hospital .
12. General cough	From cold.	<i>Umhlonyane</i>	Cured from home - boil <i>umhlonyane</i> or chew.	Cough persists, with chest pain.	Pneumonia.	Hospital .

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
13. Seizures	Difficult to diagnose.	Hospital and/or <i>Khohlela esingeni</i> (indigenous healers).	Take medication dispensed by the hospital, but if it makes patient drowsy, avoid taking them to hospital. Take patient to <i>khohlela esingeni</i> .	Drowsiness and lethargy from medication.	Person non-functional, not part of the family unit.	<i>Khohlela esingeni</i> - elite person, combined with hospital medication. <i>Khohlela esingeni</i> assists with the blood.
14. <i>Intwala zentloko</i> (head lice)	Natural for women to have this, as too busy to worry about lice. Later, in follow-up feedback session, the majority of women who were not still wearing red blankets refuted this belief.	Soap, comb and relaxing products.	Washing, combing and relaxing products.	No critical incident.	Dealt with at home.	Unnecessary.
15. Body lice and pubic lice	Shocking incident, somebody wants you not to be appealing to the opposite sex -sorcery.	Needs Xhosa medication and Xhosa rituals.	Experience and condition itself seen as a complication of a broken relationship.	Older people deal with this. Once older people express their concern, patient improves.	Manifestation of lice.	Elite woman, or traditional healer.
16. Eyes painful	Culturally related.	Older people express concern.	Older people deal with this. Once older people express their concern, patient improves.	If not improving, might require referral.	Expression of concern by older people usually helps.	Elite person, or traditional healer.
17. Ears/ears (ears seeping pus)	Painful draining of ears.	<i>Sikhikhi</i> or <i>mtshobhothi</i> .	Boil and drain; put droplets in ears.	Can complicate into closure.	Not improving.	Hospital .

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
	Possibly complication of pita.					
18. Blocked nose	Blocked nose.	<i>Umhlonya-ne, Sampot-shane</i> and <i>ityholo</i> . According to elite women, the last two are very strong, and could cause nosebleeds.	Place in hot water, inhale. Place <i>umhlonyane</i> in nose - helps to unblock the nose.	Easy to manage.	No complications.	Unnecessary.
19. <i>Imbebebe</i> (oral problems)	Deeper underlying problem. Symptom that something is wrong with the stomach. Pimples on the tongue and smelly breath.	<i>Mafumbuka</i> and sea-water.	Mix with sea-water. Elite person thinks that this is dangerous and that patient should visit the hospital.	Deeper underlying problem related to stomach and blood.	This as a manifestation of a deeper underlying problem	Hospital .
20. Mouth blisters	Due to influenza, common in summer.	<i>Isihawuha-wu, Isivumba mpunzi</i> and <i>impepho</i> .	Deal with influenza symptoms - boil the medications and steam self.	Usually when influenza wanes, the blisters heal.	No complications.	Unnecessary.
21. <i>Maqhagisa</i> (white sores at the edge of the mouth)	Dirty stomach. Elite women say it is related to a deeper underlying problem.	Medication from the hospital.	Visit the hospital.	Manifestation of deeper underlying problem.	Appearance of <i>Amaqhagisa</i> is a complication.	Hospital .
22. Facial pimples	Two causes: puberty and sorcery (if not during puberty, somebody wants you to be less appealing to the opposite	<i>Amatyhlo, isampont-shane</i> <i>isindiya-ndiya</i> .	Boil <i>sampot-shane</i> until it burns. Use in the morning to get phlegm out.	Appearance of pimples are a manifestation and a complication of an underlying problem.	Pimples caused by puberty will clear up. Those from sorcery require person to work on relationships.	Due to source in sorcery, refer to elite.

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
	sex.)					
23. <i>Isibelekoesibu hlungu</i> (painful uterus)	Pain in the lower part of the abdomen, especially when exposed to cold.	Horse dung, Vicks and MCO rubbing stuff.	Take fresh horse dung and boil. Sit on it, or on Vicks or MCO.	Not improving.	Pain growing worse.	Hospital .
24. Wounds	Blisters or open wound.	Boil bark from <i>Umnga</i> , and use to clean out the wound.	In the morning, the person applies medicine externally that you must not ingest.	Not improving.	Wound growing worse.	Hospital .

Table 4.10 demonstrates the extensive knowledge of health problems held among the older Xhosa women from FGD 3, many of which they manage at home. It also appears that they are aware of a cut-off point when their management strategies no longer work. Their most common next step is to refer the person concerned to the hospital. These women were also relaxed, and felt more comfortable discussing their use of home remedies, unlike the two other FGs, who were unwilling to share with the hospital staff what they had used at home to treat the illnesses of their relatives. It also became evident that, because said women trusted their ability to manage illnesses at home, they referred less to elite women and indigenous healers, and rather to the hospital, when their approaches seemed to be failing.

#### **4.3.3.4 Focus Group 4: The health problems that older Xhosa women manage at home**

FG 4 was the group that was the farthest away from the hospital, and consisted of women from the villages surrounding Kanya Clinic. Two of the women were very keen to participate in the FGD, while one was neutral about it, and three, despite being inebriated, still wanted to participate in the group (even though they seemed to be preoccupied elsewhere). Alcohol has become such a problem in Gusi that the Chiefs have taken a particular stance on the issue, as was explained in Chapter 3.

According to the participants in this group, they were happy that they were being asked to share their knowledge. One participant said:

*Regarding health issues for me, it was trial and error; when I grew up, I tried thinking a lot, I learnt this from my mother. I brought knowledge from my maternal home to my mother-in-law, and also learnt from her.*

The members of the group appeared to be aware of health problems in the home, as one participant confirmed:

*Coughing is another sign of a lack of well-being. Dyspnoea usually follows coughing. Dyspnoea is one of the symptoms of a severe lack of well-being. You see TB, with coughing blood and generalised weakness.*

The FG members felt that the hospital had difficulty assisting with seizures and that people preferred to visit the traditional healers for this, as one participant explained:

*Seizures are helped by medicine from the bush. Traditional healers used to cure with medication, but now one goes to the hospital. A person would be well without going to the hospital, and even now they (i.e. the traditional healers) can still cure seizures. When you go to hospital, you must let go of (i.e. stop taking) your own medication.*

When the participants was asked why she said this, she explained:

*These hospital medications make you feel dizzy. We never used to have a hospital before.*

Regarding tooth decay, a participant stated:

*Teeth used to be perfect until lately. You can die of painful teeth. This is a modern thing. For tooth decay, you must use umthene and the worms get out. There is the tooth of the home. You must go home and go through the process of ukuthonjiswa.*

Regarding HIV/AIDS and young people, a participant stated:

*Now with AIDS, you get skin disease everywhere. Girls were always in love; they used to do love play between the thighs; they also knew that they were a bank for home (meaning that, when lobola, in the form of money or cows, is paid to the home of the bride by the husband, the home grows rich). Today, children use a condom. Our children sleep and have sex. We used to stand up; we used to run. Boys were also careful, even if as a girl you were more willing to sleep with the boy. Our children are no longer girls, but women.*

In response to the researcher asking the participants what they did with their knowledge, one participant answered:

*We do not talk about it, as we will be scolded at the hospital, and this pains us. We have given up. Even if you have a sprain, you just do not touch it. How can we allow ourselves to give up? Our children must take note of our knowledge.*

**Table 4.11: The health problems that older Xhosa women from Focus Group 4 manage at home**

Health problem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incident	Rationale for relinquishing	Referral
1. Problems of the mouth, ears, and the eyes, including the white of the eye	Complaint of pain by child or adult. Child observed as being in pain.	<i>Umkhamelo</i> (medication to lower temperature) or sugar.	Squeeze fluid out of <i>mkhamelo</i> and also make a mixture of sugar, which causes pain.	Ear: If glands swell, or ear becomes infected, this can cause the ear to close up completely.	Not improving.	Hospital, or private doctor.
2. Misty eyes	This is new. Even older people used to put thread on the eye lead..	<i>Umnga</i>	Squeeze leaves, and clean the eyes out with warmed droplets.	Closing up with infection.	Not improving.	Hospital, or traditional healer.
3. Tinnitus	Closing up by evil spirit. The voice of the home is heard	Dealt with at home.	Make Xhosa beer and slaughter an animal.	Loss of energy.	Growing tired.	Traditional healer.
4. Nose	Fever starts with the nose - nosebleeds	<i>Itshungu</i> , <i>isampotshane</i> , <i>inkondlane</i> , <i>Umuncane</i> from the garden. <i>Nogangatshane</i> , <i>Umncephe</i> - Pour cold over the head, or make cold towel compression.	Boil and inhale from a distance, otherwise you can become drunk. Cold compressions; tight rope around the head.	Fever not improving, nosebleeding continues. Might be tradition- or family-related, or person getting rid of blood.	Might be pneumonia - loss of an excessive amount of blood.	Hospital, traditional healer. or ritual at home.

5. TB	Generalised body weakness. Coughing up of blood.	Take to hospital; take to somebody else.	One person felt strongly that TB could be cured by traditional medication - one bottle deals with the problem.	Haemoptysis.	Haemoptysis seen as a critical incident.	Hospital, or traditional healer.
6. Fever	Blisters and pimples in the mouth.	<i>Nohawuzela</i> and <i>gangatshane</i> .	Mix and chew raw <i>nohawuzela</i> and <i>gangatshane</i> .	Fever continues.	Symptoms growing worse.	Clinic, or hospital.
7. Toothache	Toothache can be fatal. Teeth used to be perfect until lately. This is a modern thing. Tooth decay.	<i>Mthene</i>	Place <i>mthene</i> in the mouth, and the worm comes out.	Tooth continues being sore.	Symptoms growing worse.	Hospital for extraction.
8. Tooth of the home	Painful gum.	Go home.	Receive <i>thonjiswa</i> ritual. Similar to boys going for circumcision, except that girls are not circumcised, but go through a similar ritual.	Usually helps if <i>kuthonjiswa</i> is done.	<i>Kuthonjiswa</i> - curtails the symptoms.	Unnecessary.
9. Throat	Sore throat - difficulty in swallowing.	<i>Nohawuzela</i> , <i>gangatshane</i> or salt, and <i>alani</i> .	Gargle.	Growing worse - might be tonsils.	Throat closes; difficulty in swallowing.	Hospital.
10. Throat of the home	Go home.	Drinking of Xhosa beer and slaughter an animal.	Ritual.	Not improving.	Symptoms growing worse.	Traditional healer.
11. Cancer of the throat	No cure; early diagnosis important.	Used to assist the patient to vomit, or gave a laxative.	Stopped these approaches.	Person dies.	Diagnosis takes too long.	Commonly, hospitals fail to diagnose it in time.

12. Asthma	Born with chest pain, coughing and dyspnoea.	No medication.	Severe dyspnoea.	Grows worse on misty days.	Severe dyspnoea.	Hospital.
13. <i>Umjelo</i> - worms.	Stomach-ache, vomiting, diarrhoea.	Grind the bark of a tree - Aloe - Coke, water with sugar.	Boil and drink.	Not improving.	Diarrhoea or vomiting growing worse.	Hospital.
14. HIV and AIDS - stomach	Generalised weakness and diarrhoea.	Pills from the hospital.	Take pills.	Symptoms growing worse.	Diarrhoea and illness.	Hospital.
15. Lower abdominal pains	Menstrual pains, or possibly tubes damaged by cancer.	Traditional healers for menstrual pains.	<i>Miselwa</i> (way of obtaining assistance to conceive).	Tubes harmed by cancer.	Not improving.	Hospital.
16. Painful bones	Difficulty in walking.	<i>Mpinda</i>	Use hot packs dipped in <i>mpinda</i> .	No critical incident.	None.	Unnecessary.
17. Ring-worms	Round patches on the skin.	<i>Isaqhuba</i> .	Cook and use <i>isaqhuba</i> for washing.	Not improving.	Ringworms growing worse.	Clinic.
18. Wounds	Spontaneous or injury.	Medicine of the river, <i>umsobowehlathi</i> , pig fat or urine.	Put on the wound.	Not improving.	Wound not growing better.	Clinic.
19. <i>Ijengezi</i> (first stool).	First black stool.	<i>Isichakati</i> .	Boil in water, and administer spoonfuls to the child.	'Plate' stunted growth.	Stunted growth.	Visit a knowledgeable coloured person.
20. Seizures	Falling and jerking of person affected.	Medication from the hospital, or given by the indigenous healer.	Drink medication.	Seizures only go away when a visit has been paid to an indigenous healer.	Seizures continue.	Hospital, or indigenous healer.

Table 4.11 above demonstrates that the older Xhosa women from FGD 4 also had extensive understanding of health problems that could be managed at home. It is important to note that their management strategies were not as extensive as were those of FGD 3. In terms of referral systems, they, too, appeared to swing between consulting the hospital, the indigenous healers and the clinic.

Nine illnesses were found to be common to both FGDs 3 and 4, and there were also some similarities in their management strategies. The differences were in the ailments afflicting them, such as seizures, TB and cancer. FGD 3 was adamant that these illnesses required hospital management, whereas FGD 4 swung between hospital and indigenous healers for the management of the illnesses concerned. Table 4.12 below lists the nine illnesses that were found to be common to the two groups.

**Table 4.12: Nine illnesses common to FGD 3 and FGD 4**

- 
- *Isisu sokuntshintsha* (period pains)
  - *Ijengezi* (first baby stool)
  - TB
  - Seizures
  - Painful eyes
  - Ears/Ears of Pita
  - Nose bleed
  - *Isibeleko esibuhlungu* (painful uterus)
  - Wounds
- 

#### **4.3.4 Critical incidents that emerged from the case studies from the four FGDs**

Participants from the four FGDs spontaneously narrated health-related critical incidents that they had experienced with their families, including how they had managed the incidents.

Seven critical incidents emerged:

Focus Group 1: A troublesome daughter; a hut that required repairs.

Focus Group 2: A response to dissatisfaction with health care.

Focus Group 3: The birth of a child, support for the newborn and its consequence.

Focus Group 4: Three levels of desperation and strength, and the celebration of a woman's birth process.

##### **4.3.4.1 Focus Group 1: Critical incidents**

- ***Critical incident 1 – A troublesome daughter***

When FG1 defined the nature of health and illness, troublesome children were identified as being a critical contributor to both health and illness. The women in this group maintained, 'You can die from this'. This critical incident was narrated by one of the older Xhosa women, who described the difficult relationship that she was currently experiencing with her daughter:

*I am not being paid, and my health is undermined. I live with the grandchildren. I have nothing at hand, as I am not receiving an old age pension as yet. The child grant is being paid to the mother of the children. When I gave birth to a girl, I felt alright and happy, except that mine takes all the money for child support. I want to report her to the police to catch her, but I fear she will hit me. My older sister from my husband's side helps me a lot. We look after each other. When somebody looks*

*after your stomach, that person is taking proper care of you. This is not just a woman; she is a man - a provider; she feeds me.*

This critical health-related incident influenced the decisions that this older Xhosa woman could make. She was struggling with her grandchildren, whom her daughter appears to have abandoned. She wanted to report her daughter to the police, but was afraid that her daughter would retaliate against her, and so her hands were tied. Her best coping skill was to obtain support from her sister-in-law, who provided her with food. This had strengthened their relationship. The older woman saw her sister-in-law in a new light, and acknowledged that women, too, could take over the role that is usually played by men in this village - that of bringing food to the table. She elevated the status of her sister-in-law to that of 'a man'.

This critical incident demonstrates how troublesome children can indirectly have a negative impact on health. It also demonstrates the importance of food security to health. This older woman struggled to feed both herself and her grandchildren, and appeared to be stressed and anxious regarding her daughter. All these factors have had a negative impact on her overall health.

- ***Critical incident 2 – A hut that required repairs***

This critical incident was narrated by the same woman as narrated the above incident. However, it was during the feedback workshops when the researcher returned to validate the transcripts of the FGD and the in-depth interviews. The feedback workshop began with each woman being asked how they had been since the FGD and the interviews. When it came to the older woman, she explained that, during the summer, heavy rainfalls fell, and that the only hut that she owned had been partly demolished. She narrated the following:

*Things are not working for me, I do not have a place to live, as the only hut I had has fallen down from heavy rainfalls - now I do not have a place to live, and I do not know what to do.*

The other older Xhosa women entered into the conversation, saying:

*We have been telling her for some time that she must start making bricks for mending her hut. Once she starts, we will join her and assist.*

She answered:

*Don't you understand that I have a painful back - that I have been going to the hospital for several times for this back. I cannot make bricks with this sore back.*

The other women did not fully accept what she had to say, and they continued:

*Even if you have a painful back, you can start slow by making even one brick a day, and immediately you start we will join you.*

The older woman started to become upset, and said:

*Do you want me to go against my doctor's instructions? He has instructed me to rest my back, and that is what I am going to do, and if you continue forcing me to start making bricks, I will report you to my doctor. (This was said with much confidence, and a certain type of coyness, as if she were saying "I now have a weapon with which to fight you.")*

After this, it appeared that the other participants were silenced – this older Xhosa woman had found a weapon with which to silence them - she would report them to the doctor, who had given her instructions that she had to take care of her back, even if it meant staying in a dangerous hut that could fall on her and her grandchildren. The intermediate and long-term health of herself and of her grandchildren was at risk, and the older Xhosa women were prepared to assist her. However, instead of working with them, and seeing how she could use their help, she chose to hide behind the doctor's instruction, thus isolating herself from the support that she could otherwise have received from her village to rebuild her house and to re-establish her own health status and that of her family. In some way, she was responding differently to how the other women of this village would have chosen to respond, in that they would have put the health status of their home first before that of their own. She was approaching health and illness from an individualistic approach, and it appeared as if she were part of the new changes that were happening in this village.

#### **4.3.4.2 Focus Group 2: Critical incident**

- **Critical incident 3 – A response to dissatisfaction with health care**

During the FGD, the participants did not mention a critical incident. Six months later, in the feedback workshops (which took place with a smaller group, from which the male members of the group were also absent), these women enjoyed hearing about, and validating results, from FGs 3 and 4. They mentioned that the older women from these FG were using items and methods that had been used in the olden days, and that they could remember these things being used in their own homes by their own grandmothers. They seemed to enjoy this

function of validating the other group's data, in terms of them being able to confirm their accuracy.

As the women in this group preferred to take their family members to the hospital for the treatment of all illnesses, the researcher wanted to understand whether they were satisfied with the care that they received there. The participants said that they had fabricated this story, because they had lost hope that the hospital would assist their relatives, and were now taking them to an indigenous healer. They could not inform the hospital staff about this. They reported as follows:

*Sometimes we are happy and sometimes we are not. You take your relative to hospital being very ill. The relative gets admitted. You continue to visit the relative to check how she/he is doing, and then you find that your relative is getting worse. You start preparing home medication, and quietly bring the medication to use while in the hospital. You tell your relative to hide the medication from the doctor. You inform them to hide the bottle under the pillow. If the relative does not get better, you ask permission from the doctor for the relative to go home for a short visit, as there are close relatives that will be coming from afar, and you think the relative will benefit from seeing them. A small feast is planned for the relatives. Meanwhile, you know you are taking your relative to a traditional healer.*

This critical incident demonstrates that the women in this FG had a level of mistrust towards the hospital and its health care providers, even though they had chosen to use them as their main health care provider.

#### **4.3.4.3 Focus Group 3: Critical incidents**

- **Critical incident 4 – The birth of a child**

This FG had strongly expressed the need for caring for all children as if they belonged to all in the village. The critical incident that is related below regards the birth of a child.

What is the management for a pregnant woman?

*A person is massaged at four months, six and nine months, and the 9<sup>th</sup> month would be the last month. The woman goes on all fours. There were women assigned to massage the stomach, and during this time head scarves are loosened, and any tight attire is loosened. During this time both women will be kneeling down and open their thighs, already mimicking labour and birth. A person responsible for massaging the stomach would first wash their hands.*

Are there still women who give this type of support for the management and support of a pregnant woman?

*Yes, although many people use the hospital. When you are pregnant, you develop a sore leg (hip joint - inyonga) or lower back pains, swelling of the feet and hyperextension of the back. Heartburn, the heartburn is not only related to illness, but also to what you take. By taking green natural vegetables, you can get rid of heartburn. Or Unongotyozane - the green one; you chew it, and this does get rid of heartburn.*

Mrs Z. had not given birth at the hospital to any of her nine children.

At home, who assists with delivery?

*People do not need help - older women wait on you, and will be checking how long it was (i.e. is) taking for you to give birth. Women of that household will wait on you while you are on all fours until you give birth. There are many ways of giving birth, and each woman has her own style of giving birth. It all comes naturally. Some go on all fours, and others lift one leg, but the most important thing is to protect the head from hitting the ground, as the child dies from this.*

How do you protect the head from hitting the ground?

*The head does not hit the ground, but the head hits on the thigh.*

Who teaches you to protect the head using the thigh?

*God teaches you how to protect the child. The ambulance and the nurse do nothing for you. Even at the hospital, they do nothing, except wait upon you until you give birth. They only stand as guards to see that everything goes well. A nurse does nothing for you; they only intervene when there is a problem.*

Amongst all of you, is there anyone who ever gave birth by operation?

*No.*

Critical incident 4 shows the knowledge that the women have regarding the birth process. It appears that they have their own pre- and antenatal care, and that they are aware of some of the illnesses that pregnant mothers experience, and how to manage these at home. They see giving birth as a natural process that gatekeepers must watch in case there are complications. They perceive that the role of the hospital is only to manage birth complications. All these women had normal vertex delivery. The researcher asked about complications:

Were the children well, since you never had an operation?

*My eighth child was disabled and - this was a delayed birth, and the only child I gave birth to at the hospital. His feet during birth were attached to the head and the knees do not work - he cannot walk, but shuffles on his bottom. He is 14 years old. He can talk and is alert, except in his movement.*

Is there anybody else who gave birth to a child with disability?

*Yes, my son is in a special school in Sinethemba in Ngqeleni.*

What is wrong with him?

*He learns slowly, and is different from other children.*

The researcher watched the other women as the above-mentioned two women were telling me about their disabled children. There seemed to be a general feeling of compassion from the other women. It was not excessive, and the two women seemed comfortable talking about their disabled children. These were the only disabled children from 224 normal vertex deliveries among the 36 women from the four FGs.

- ***Critical incident 5 – Support for the newborn child and its consequence***

The second critical incident that this FG related was one of mother and child care after delivery in the maternal home. In polygamous relationships, internal arrangements, responsibilities and outcomes are developed regarding taking care of the home. The wife who has given birth does not stay in the married home, but, for a while, returns to her maternal home to look after herself and her baby. The following narrative was related by the first wife of the Chief (who was one of three wives). She explained this incident in an individual interview with the researcher and the research assistant. She spoke about the Chief's second wife as 'her sister'. We asked about how it happened that the Chief took a second wife. She explained, "*It happened when I went home - my own home to give birth to the second child.*" In those days, apparently women stayed away from their husbands geographically and sexually after having given birth, so as to be able to recuperate from the birth and so as to start raising the child. There was a belief that if the wife had sexual relations with the husband before the child was three years old, the child would not thrive (*ulalelwe*). She explained:

*While I was at home, the Chief could not cope with the household demands and his own personal needs, as he was staying with elderly sisters. He decided to take a second wife. Then he came to report to me that he had taken a second wife, because his sisters cannot (i.e. could not) take care of him. They could not even cook for themselves, as they were far older than him.*

When she was asked about how she felt about this, she stated:

*Anger in the beginning but then there was nothing I could do.*

She was next asked, when he had told her about this, what did he expect from her?  
*To say what I wanted to say, but underneath it felt that he also expected my acceptance. The worse part of this was that this woman had already been married.*

What difference would it have made if she was a girl who had never been married?  
*This one already knew all the tricks of the trade of being a married woman.*

Was it somebody you knew?

*I did not know that he had intentions of marrying her, but immediately he mentioned her name, I knew who it was and that there might be problems with my marriage. So I went back home.*

How has it been staying with her?

*I took her as my sister, and it has been fine.*

Did you always stay apart from your husband?

*No, there was that time when I too lived with (the) Chief's sisters, and then I and my husband were given land by the paramount Chief, who was the present Queen's husband in Gusi. When we moved to Gusi, we lived in separate houses.*

How did the third wife come to marry the Chief?

*This is the situation; it is difficult to handle. I feel that my blindness developed from a painful heart from that situation.*

In response to the interest expressed by the researchers in the situation, she continued as follows:

*It all started with my son dying in a car accident, and his young wife being left under my supervision and support. I felt quite sorry for the young woman, and built her a home within the same yard as my own household. I gave her adequate independence to date other men, as she was quite young. She had two children from these new acquaintances. Then I started to have a suspicion that something was going on between her and the Chief. One night, I woke up to check what was going on, as I heard voices coming from the young woman's home. I caught them red-handed. I chased them both out of my household. Later, the Chief married her - not a customary marriage like his previous two wives, but a court marriage, and built her a house.*

Apparently, rumours circulated through the village that this young wife had a strong hold on the Chief. Although he spent every day at the Great Place, at which the first wife resolved disputes, every night he spent with the younger wife. His younger wife was said to have made him sign a will stating that he would leave all his policies and money for her. The village seemed to support the cause of the first wife. Little was said about the middle wife, who appeared to be seen as a shadow. The researchers then left the first wife, jokingly saying to her that they wanted to know everything that transpired in this village.

This critical incident demonstrates the support systems that were developed to support both the mother and the child after delivery, which were aimed at assisting the child to thrive, so that the mother did not need to split her attention between the child, the home and her husband. Returning to the maternal home is also used as a form of contraception. However, such a support system left the man alone, with no one to run the home and to support him. In the case of the Chief, he took another wife, due to his own inadequacies. It also appeared that this was done unilaterally, and, although the first wife was told about his intentions, she was expected to accept the decision. In this case, it appeared as if the Chief did not follow the established norm, as he married a woman who had already been married, thereby giving his first wife the task of integrating a woman into his home who appeared already to 'know it all'; and his third wife was one of his own in-laws - the wife of his dead son. The first wife blamed her blindness on this incident.

However, although the first wife had lost her husband to the younger wife, she continued to have the full support of the village. The Chief had no choice, in the fact that he had to resolve all the disputes of the village in her home, 'the *Inkundla*', and so she continued to maintain the status of being his first wife.

#### **4.3.4.4 Focus Group 4: Critical incidents**

- ***Critical incident 6 – Levels of desperation and strength***

Four critical incidents were presented for FG4. Three showed some of the predicaments that women experience as first-line practitioners, and the fourth one was an attempt to validate the traditional birth process.

##### *The predicaments that women experience as first-line practitioners*

Critical incident 6a was described as follows:

*As a woman, when your child is very ill and you have tried everything you know of and you have consulted with your mother-in-law, and she also has tried to link with other knowledgeable women, and this has not helped, you usually dream at night of either your mother or grandmother, or an important family relative guiding you on*

*where to go and get medication for your child, even if this might be in the forest. When you wake up, you would go to the exact place and find the medication described in your dream there, and prepare it in the way in which you have been told in your dream, and this usually helps your child. We believe that for every illness there is a herb ready nearby your birthplace to cure that illness. It is only for illnesses that are brought by outsiders that there is no herb ready to cure that illness.*

Critical incident 6b was described as follows:

*When your child or loved one is ill, and you have to take him to the hospital, this usually takes the whole day, and at that time you are not sure whether the help you are going to get is going to assist your loved one. So what you do is to wake up early, prepare your own indigenous medicine and leave it ready. Then, when you come back and you are not happy with the management at the hospital, you give your loved one your own indigenous medication.*

Critical incident 6c was described as follows:

One of the older woman told a story about one of her relatives, a young woman, who was brought to her very ill. A snake had eaten her from below, and had ruptured her vagina, to the extent that she could see her own intestines. This was shocking and scary for the older woman, but because she had confidence in the healing components of herbs, she started boiling some, and used them to clean the young woman, and then used them as padding. She repeated this ministrations several times. The woman began to improve, until she was completely healed. Although this case left the researcher with many unanswered questions, the older woman was not ready to answer them.

The above three events demonstrate the level of desperation that these older Xhosa women feel at times. They also demonstrate their determined attitude towards the health of their families - they do not give up, and are literally prepared to try out any proposed solution.

- ***Critical incident 7: The celebration of a woman's birth process***

The last critical incident for FG4 concerned childbirth - validating the critical incident that had been dealt with in FGD3, and demonstrating the skills of older women in matters of antenatal care and childbirth.

*When you are pregnant, antenatal care happens at home. On a sunny day, your midwife would warm water to clean and warm her hands to assist with rubbing the stomach and doing exercise to ensure the smooth process of giving birth when the time comes. They bring isihlambezo from the field, so that the baby can settle well in*

*the stomach. All these things are kept outside where the wood is. Also, when the pregnant woman brings water from the river, when she is walking on a place going down, she would start running, so that she must not get tired when giving birth. When the birth pains start, you tell an older person, and you would be kept inside with a warm fire and hot water is boiled. They would assist you to exercise, with their head scarves off. When it is time to give birth, when the child or afterbirth is struggling to come, the mother is given an empty bottle to blow into.*

*When the afterbirth has not all come out, it can come out three days after giving birth. When giving birth, we do it differently than the hospital; we go on all fours, so that we can observe everything when it is coming out. The older women will go and get grass to put by the woman who has just given birth. They take the reed and cut the umbilicus. If a child is not breathing when you get it out, you blow into the child.*

*They also picked Ngcelwane, mixing it with berries and dust from the fire, on which the umbilicus could fall. Women become busy and cook porridge for you. After eight days, you are given cow dung to clean the floor to i.e. when you get up. You collect the grass you were sleeping on, and throw it at night in your own private place.*

*At this time, while you are raising the child, you do not have a sexual relationship with the husband, otherwise the child will lose weight. The husband must go and satisfy himself somewhere else. He will do this in secret, and when you start feeling jealousy, he will scold you that he cannot have sexual relations with you, as this will kill his baby.*

*I used to turn my child in my stomach myself. I learnt this from my mother. She used to help the whole village. You handle pregnant women until the 9<sup>th</sup> month - you warm your hands in water in a tin. The woman squats, and you turn the child. When she is done giving birth, you take sharp grass from the roof to cut the umbilicus. The fallen umbilicus and the first stool all gets hidden in a crevice in the wall of the hut. All these things strengthen the baby.*

*After the baby is born, you give isichakathi and boiled water, and give this to the child to drink to pass the first stool. In the past, there were no problems with things like bleeding when you gave birth. There are a lot of ailments today. When we were pregnant, we used to be well fed with pumpkin, oranges and beans, so that the child can have good eyesight.*

The following points were noted as being similar to the antenatal care given at the hospital:

- When the women provided antenatal care, they first warmed and washed their hands.
- Part of the antenatal management involved rubbing the pregnant woman's stomach, giving her exercises and turning the child.
- The women were aware of the need to keep fit during pregnancy.
- They encouraged doing exercises during birthing.
- When the head of the baby was struggling to come out, they made the mother do breathing exercises by blowing into a bottle.
- The majority of women had normal vertex delivery, and then abstained from sex, in order to give them time to heal, and the child time to grow - this was also used as a form of contraception.
- They were aware of the need for good nutrition during pregnancy.
- They were aware of generalised, lowered immunity, including severe bleeding during delivery, which was not the case in earlier times.

#### **4.3.5 Perceptions of the older Xhosa women about why they were consulted when a family member was ill**

FGDs 3 and 4 were asked about who consulted them in the home when a family member was ill (it was not possible to ask FGDs 1 and 2 about this, as they seemed reluctant to talk about any healing approaches practised at home). The women narrated what they perceived to be the rationale for why they were consulted by their families when a family member was ill. From this, biographies were developed, which outlined the life plots and turning points in their lives that helped to clarify their role in the family unit. Themes that emerged were informed by the categories that were the cornerstones of the narratives of the women from FGDs 3 and 4. The outcome of this analysis is summarised in the table below.

**Table 4.13: Summary statements of the older Xhosa women from FGs 3 and 4 regarding their roles, attributes and skills; and where and how these were learnt**

<b>Roles, attributes and skills; and where and how these were learnt</b>	<b>Supporting statements</b>
<b>Roles played:</b> <ul style="list-style-type: none"> <li>• Protect the home ('the hen')</li> <li>• Look after the home ('the shepherd')</li> <li>• Double role of protecting and looking after the home</li> <li>• Connector with the outside world</li> <li>• Preserver of quietness and harmony</li> <li>• Problem-solver and guardian of the family</li> </ul>	<i>Sees what is wrong first, even illness; Being the eye of the family life, experiences as always thinking about the family; Assisting the young wife of their son, in some way they are assisting their young son.</i>

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<ul style="list-style-type: none"> <li>• Play her role - be a woman - and look after the home</li> </ul>	<p><i>This is about being a women, explaining to the visitors. It is to put your skirt (umbhanco) around your waist with confidence and determination; You have to put on your pelvic blanket; You are the guardian of the family. Nothing comes right when a mother is not there. All the problems of the home depend on her to think about the family and to collect rainwater.</i></p>
<p><b>Skills and attributes:</b></p> <ul style="list-style-type: none"> <li>• Self-confidence</li> <li>• Determination</li> <li>• Patience</li> <li>• Humility</li> <li>• Dignity</li> </ul>	
<p><b>Where and how skills were learnt:</b></p> <ul style="list-style-type: none"> <li>• The maternal home</li> <li>• Married life</li> <li>• Having sex, and falling in love with your husband</li> <li>• Falling pregnant</li> <li>• Giving birth</li> <li>• Raising children</li> <li>• Learning from the mother-in-law</li> </ul>	<p><i>You are taught at home: we are marrying you to that household. It is to lie down with a man. You start having sexual relations with him, until you are pregnant, and the whole aim was that you must give birth, because once this happens, you are sealed to this household.</i></p>

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The women described themselves as the 'guardians of the family', who must preserve peace, quietness and harmony. These are important health determinants. They ended up by saying:

*Nothing comes right when a mother is not there. All the problems of the home depend on her - to think about the family and to collect rainwater.*

It appeared to these women that it was important to have determination:

*It is to put your skirt (umbhanco) around your waist with confidence and determination - you have to put on your pelvic blanket.*

All this they learnt early in their lives in their own maternal homes, in which it appears that they were being prepared for the role that they had to play as married women. Then the mother-in-law completed the tutoring that was started in the maternal home:

*You are taught at home: we are marrying you to that household. You do not know even this person you are being married to. You look at his face; his face looks huge. It is to lie down with a man. You start having sexual relationships with him until you are pregnant, and the whole aim was that you must give birth, because once this happens, you are sealed to this household.*

Ultimately, you reconcile with the situation and adapt:

*You fight a lot with this person. Ultimately, you do fall in love with this person. In the beginning, you do not know his smell; it irritates you. Then later, you fall in love with this smell, and you become jealous. To be a woman is to give birth and the child gets thrown out of your uterus (kukuphumakomntwanaathibhoqo).*

#### 4.4 SECTION 2: SECONDARY SAMPLE

The secondary sample included the elite older Xhosa women and their family members. The findings of this group were used to validate the findings of the primary sample.

##### 4.4.1 In-depth interviews with the elite group of older Xhosa women

Two main questions regarding their understanding of health and illness, and why they were consulted by other women when somebody was ill focused the discussion with these women. They were also asked to narrate critical incidents that were brought to them to manage. This did not bring results, as the elite women resisted narrating any critical incidents they had managed. The following is what one of them said when asked about illnesses that she managed, and why people came to her when they were ill:

*I am not going to go there. Those are other things that do not need to be brought out.*

One person who had experienced a critical incident that was managed by one of the elite women also did not want to give an account of it. It appeared that there was a certain level of confidence and confidentiality regarding the healing practices and the responses of the elite Xhosa women to the ill person. Some key issues were noted.

In relation to their management strategies of health problems that were referred to them, the following is part of what they had to say:

*In general, a person takes a week or slightly more. What is important is to see a person getting better. The one with diarrhoea with blood stains, the diarrhoea must get better and the blood stains must stop, and the one coughing out blood, this must stop and the sputum should be clear.*

They saw early diagnosis and referral as important for good outcomes:

*When an illness has not been dealt with quite early, it is difficult to cure. If you start a person on medicine, one bottle should be enough if you are going to assist a person. When a person is doing better - a person is given a certain medicine called mafubuka; that medication clears the stomach.*

They seemed to contradict the perception of biomedicine that traditional medication is given without consideration for dosage and frequency, as the following extract shows:

*You grind them, and put in a bottle with cold water, and a person drinks two tablespoons three times a day.*

They were quite aware of diagnoses related to the chest, as is pointed out in the following extract:

*You do get chest problems, even if you are not coughing. The chest becomes closed, and shows signs of breathlessness.*

They were critical of some of the hospital management approaches:

*It is bad that in hospitals a woman is asked to lie on her back when giving birth. You need to breathe deeply from the bottom of your stomach. You must call the birth process from afar, deep in your stomach.*

They were also critical of the management skills of the older Xhosa women. They spoke of the need not to use certain herbs, as people's immunity has declined. These herbs, especially those for stomach problems, could exacerbate the condition. They spoke of how corrosive sea-water is, and that it could worsen diarrhoea, especially in people with HIV/AIDS. Below is a summary of the perceptions of the elite older Xhosa women regarding their roles, attributes and skills, and how and where they were learnt.

**Table 4.14: Summary of the perceptions of the elite older Xhosa women regarding their roles, attributes and skills; and how and where they were learnt**

<b>Roles, attribute and skills; and how and where they were learnt</b>	<b>Supporting statements</b>
<p><b>Roles played:</b></p> <ul style="list-style-type: none"> <li>• Role model</li> <li>• Teacher</li> <li>• Sharer with other women</li> <li>• Referrer to others</li> <li>• Consulter of the knowledgeable</li> <li>• Abider by the truth</li> <li>• Learner from the mother-in-law</li> <li>• Learner from life struggles</li> <li>• Not holder of grudges</li> <li>• Avoider of conflicts</li> </ul> <p><b>Skills and attributes of the older Xhosa women:</b></p> <ul style="list-style-type: none"> <li>• Observation and learning from others</li> <li>• Being a good listener and being selective</li> <li>• Practising and repeating</li> <li>• Awareness of limitations</li> <li>• Willingness to learn</li> <li>• General willingness to be client-centred</li> <li>• Practised in the art of being a woman: <ul style="list-style-type: none"> <li>○ Having sex with your chosen husband and falling in love with him</li> </ul> </li> </ul>	<p><i>Role model to the younger wife. Give her messages that will stabilise her in her household. Share with other women what stabilises you.</i></p> <p><i>You are stable; you observe things happening and do not react if they have nothing to do with you. You do not hold grudges, and you avoid conflicts. You listen only, and answer what comes to you.</i></p> <p><i>Although my father was a traditional healer, he took him to the hospital. He also went to a traditional healer, because the child had convulsions. Also people are not alike; What I have is that I work together with you and prayer. I would go to those who are more knowledgeable, observe what they do, and then tomorrow I would repeat this. My father assisted me with this knowledge. And he also was assisted by another medicine man. African people do not ask too</i></p>

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<ul style="list-style-type: none"> <li>○ Giving birth to his children</li> <li>○ Respecting the household</li> <li>○ Supporting one another as women</li> <li>○ Listening to the mother-in-law</li> <li>• Ancestral reverence</li> </ul>	<p><i>much and everything - You just approach a person asking for medication for that illness without asking a lot.</i></p>
<b>Where and how skills were learnt:</b>	
<ul style="list-style-type: none"> <li>• Learned from the elders</li> <li>• Knowledge is carried by word of mouth and sharing</li> <li>• Listening and less questioning</li> <li>• The mother-in-law - a critical component</li> </ul>	<p><i>It is to depend on the mother-in-law. When you are a young wife, when you marry, you are told that here is your mother, here is your father. Their role is to unpack difficult problems for you.</i></p>

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#### **4.4.2 In-depth interviews with family members of the elite older Xhosa women**

The researcher interacted with family members of the elite older Xhosa women to explore their understanding of who mainly managed health problems in their home situation, and why these individuals were consulted. Three case studies arising out of these interactions are presented here - two are from the grandchildren of the elite older Xhosa women, and one is from a daughter-in-law.

##### **4.4.2.1 Case Study 1: The granddaughter's perspective on her grandmother**

*Here at home we are nine people. Three children belong to grandmother. Others have died. Father was stabbed; another had a car accident. Our mother was coughing; later, they found out that she had TB.*

Grandmother joined the conversation.

*I was not here; I had gone to clean my stomach. I felt that my stomach was congested. Now I feel some relief; my stomach is lighter.*

In the absence of the grandmother, her grandchildren said:

*Our grandmother's healing gift continues to grow; it is not getting extinct. The people who used to come to her used to get better. The only problem is that they do not pay. She would give medication to the children.*

With what ailments does she deal?

*If a person brings an ailment, and gets medication from grandmother, that person gets well. The white illness is far more complicated and expensive. A person loses work. Our grandmother usually asks for appeasement from the ancestors. Our grandmother does not go to church. She goes to the church of being a traditional healer. Our grandmother is a person of the spirits. Other religions are in conflict with her spirit. When she wants to evoke her spirits, she asks for hands from the neighbours - that means the neighbours join in her calling of the spirits by clapping*

*their hands. She also has a drum. The neighbours also come to grandmother when they are ill.*

Does your grandmother ever ask anyone to go to the hospital?

*Yes, she knows what is suitable for her.*

Does she not send them to other traditional healers?

*No, she oversees this herself, and if it requires more than her capability, she sends the person to the hospital. My grandmother does not see the contradiction between what she is doing and the hospital; she sees these as complementing each other.*

Do you foresee a time that your grandmother's medicine could be used in the hospital?

*No, the doctors reject Xhosa medication. When you go to the hospital, they ask you if you have used Xhosa medicine. Then they ask you: why have you come here if you can medicate yourself? There are people who react badly to Xhosa medication. The most important thing is that one must first use one type, preferably Xhosa first. The medications do not mix. My young child reacts badly to Xhosa medication.*

Who are the people who have been helped by Makhulu?

*There is one he woke up from the deathbed, and another mother who was struggling to give birth.*

Of which medications do you know?

*Ingcimamlilo: for burns and wounds.*

*Usikhikhi: for rash and earache.*

*Ingcelwane: for stomach-ache.*

*When I am not doing well, I go and pick up medication, and if I do not recover, I go to the hospital. Umlungu mabele is for the worms; it burns them, so that they do not come out through the mouth.*

*Peach leaves are also helpful. You boil them. Peach leaves are also helpful when animals have wounds.*

*Umjelo: for cramping stomach. When you have palpitations, you can also chew umjelo - its bark.*

*The roots of ubazi: this helps with the placenta that is struggling to come out.*

What makes your grandmother a healer?

*The greater people gave her this gift. Spiritually, she is helped to see the medication while sleeping. And then she wakes up to seek for it and to heal people. This started with her father. I am not sure whether it is still her father who gives this to her through a dream.*

How do you handle this whole healing thing of your grandmother?

*We are a bit careless about it; it is as if it is like the groceries, which will always be replenished when they are finished. We forget that one day she will not be there.*

#### **4.4.2.2 Case Study 2: Daughter-in-law (of a household close to the hospital)**

*My mother-in-law is the one who stands up when somebody is not doing well. She picks herbs. Other herbs she plants. Sometimes she is called to other households when somebody is not doing well.*

*What makes her be a mother is that she moves fast, and what makes her move fast is that she has patience. I start with my mother-in-law when my child is ill. Children do not watch when she selects these medications, but she also teaches me, although I struggle to understand them at the same time. Others she plants.*

Do you not want to do this for yourself sometime?

*I am afraid that I will not mix it the way mother mixes it.*

Is there a time when your mother-in-law helped a person who was very ill?

*Yes, sometimes mother is called next door. The person had dyspnoea, and the person died. She assisted one grandfather.*

Do you sometimes give a child who is not doing well to your father-in-law?

*No, it is the mother whom we trust and who jumps first. A person who is the father is hard. A mother is like this, because she is the birth giver. I, too, am patient, and once I am old I see myself having the same qualities as my mother-in-law.*

#### **4.4.2.3 Case Study 3: The grandchildren**

The researchers arrived in a household while the elite older Xhosa woman was away visiting somewhere, and while they were waiting for her, they had an opportunity to speak to the grandchildren. The household was a stable one that looked as if they were managing to handle their struggles, and as of they were coping with their present circumstances. The researchers wanted to hear from them why they had been referred to their grandmother as an elite Xhosa woman. One young man, who seemed to be the closest to the grandmother, was quite vocal about the situation. He told us:

*Our grandmother explains to me where I should go in the garden, and sometimes in the field and the forest. She explains exactly how the herb looks like, so that I would know what to pick up. We like our grandmother a lot, as she keeps the peace of the family, and keeps the family together.*

The above case studies further affirm the role of the elite Xhosa women with regard to being trusted as far as the well-being of the family is concerned, and with regard to being consulted when a family member is ill. The table below summarises the attributes and skills, from the perspective of the family members of the elite Xhosa women.

**Table 4.15: Summary of attributes and skills from the perspective of the family members of the elite Xhosa women**

<b>Skills and attributes of the older Xhosa women</b>	<b>Supporting statements</b>
A teacher and a role-player	<i>She also teaches me, although I struggle to understand them; Stories of the grandmother used to send him to fetch some herbs; Concern of the grandchildren not observing and learning from the grandmother's practices.</i>
A trusted person who is patient and inspires one, and who keeps the cohesiveness of the family	<i>I am afraid that I will not mix it the way mother mixes it; I start with my mother-in-law when my child is ill. What makes her be a mother is that she moves fast, and she moves fast because she has patience.</i>
Self-confident, aware of her own limitations, and consults others who are knowledgeable	<i>Yes, she knows what is suitable for her; No, she oversees this herself, and if it requires more than her capability, she sends the person to the hospital.</i>
Draws energy and power from ancestral relevance and support from neighbours	<i>Our grandmother does not go to church. She goes to the church of being a traditional healer. Our grandmother is a person of the spirits. Other religions are in conflict with her spirit. When she wants to evoke her spirits, she asks for hands from the neighbours (meaning that the neighbours join in her calling up of the spirits by clapping their hands).</i>
A vulnerable knowledge that is observed, practised, and carried by word of mouth	<i>We are a bit careless about it; It is like the groceries, which will always be replenished when they are finished. We forget that one day she will not be there; Children do not watch when she selects these medications, but she also teaches me, although I struggle to understand them at the same time.</i>

#### 4.4.3 Combined attributes and skills of the older Xhosa women from the perspective of the older Xhosa women, the family members of the older Xhosa women, and the elite older Xhosa women

The table below summarises the attributes and skills of the older Xhosa women from the perspective of the family members, the FGDs 3 and 4, and the elite older Xhosa women.

**Table 4.16: Summary of attributes and skills, from the perspective of the families, FGDs 3 and 4 and the elite Xhosa women**

<b>Roles</b>	<b>Skills and attributes</b>	<b>Where skills and attributes were learnt</b>
<ul style="list-style-type: none"> <li>• A teacher and a role- model</li> <li>• Inspirer of others</li> <li>• A trusted person</li> <li>• Keeper of the cohesiveness of the family</li> <li>• Referrer to others</li> <li>• Abider by the truth</li> <li>• Holder of no grudges, and avoider of conflicts</li> <li>• Protector and guardian of the home, in multiple roles (both 'hen' and 'shepherd')</li> <li>• Connector of the home with the outside world</li> <li>• Consultant of others who are knowledgeable</li> <li>• Problem-solver and guardian of the family</li> <li>• Sharer with, and supporter of, other women</li> <li>• Learner from the mother-in-law</li> <li>• Learner from life struggles</li> <li>• Drawer of energy and power from ancestral relevance</li> <li>• A woman, in looking after the home</li> </ul>	<ul style="list-style-type: none"> <li>• Observant</li> <li>• Willingness to learn from the mother-in-law and from others</li> <li>• Good and selective listener</li> <li>• Practised, due to repetition</li> <li>• Self-confidence</li> <li>• Determination</li> <li>• Patience</li> <li>• Humility</li> <li>• Dignity</li> <li>• Awareness of limitations</li> <li>• General willingness to integrate</li> <li>• Client-centeredness</li> <li>• Practised in the art of being a woman</li> <li>• Awareness of ancestral relevance</li> </ul>	<ul style="list-style-type: none"> <li>• From the marital home</li> <li>• From the mother-in-law</li> <li>• Through married</li> <li>• Through raising children</li> <li>• From other women</li> <li>• From life's struggles</li> <li>• From the elders</li> <li>• By word-of-mouth and sharing</li> <li>• From listening and some questioning</li> </ul>

#### 4.5 SECTION 3: TRANSITIONAL OPPORTUNISTIC CONVERSATIONS WITH THE PEOPLE OF GUSI VILLAGE

This section covers the transitional opportunistic conversations (TOCs) conducted with the people of the 18 villages of Gusi. Outlined in Table 4.17 below is the presentation of critical issues that emerged from the TOC that the researcher held with five (5) transitional

opportunistic conversers that were linked, and had an influence on, the key aspects of the main research question:

**Table 4.17: How the transitional conversations contributed to the study**

Transitional conversation	Key aspects that emerged	Contribution to the study
1. Two young wives	<ul style="list-style-type: none"> <li>• Complained about the control of their mother-in-law on them.</li> <li>• To them, their mother-in-law appeared to utilise her health knowledge and the knowledge that she held about their husbands as a form of control on them.</li> <li>• One had left her husband and was staying on her own; the other was thinking of leaving the mother-in-law's household to start her own household.</li> </ul>	<ul style="list-style-type: none"> <li>• Brought a new perspective regarding the attributes of older Xhosa women.</li> <li>• Showed the impact of change and new models of practice emerging in village life.</li> <li>• Demonstrated the importance of not generalising.</li> </ul>
2. Village mourners	<ul style="list-style-type: none"> <li>• Complained bitterly about the death of relatives who were young male adults.</li> <li>• Perception that the life of a black person was not important to the white doctors.</li> <li>• Begged the Chief to intervene.</li> </ul>	<ul style="list-style-type: none"> <li>• Validated the entrenched perceptions between the village people and the health professionals.</li> <li>• Explained how the Chief mediated between the newcomers and the villagers - the explanation included new knowledges.</li> </ul>
3. Retired clinical nurse practitioner	<p>Narrated stories of:</p> <ul style="list-style-type: none"> <li>• Young nurses taking patients out of the hospital for IHK intervention.</li> <li>• Traditional healers begging for parts cut out of white patients who had undergone surgery, in order to make medications.</li> <li>• Blame of the mothers of children who had died from diarrhoea for using bottle feeding.</li> </ul>	<ul style="list-style-type: none"> <li>• Dangers brought by adopting new approaches to people who have little understanding and knowledge of these approaches.</li> <li>• Awareness of vulnerability of both indigenous and biomedical knowledge.</li> <li>• Awareness of double standards of local health professionals.</li> <li>• Recognition that traditional healer knows</li> </ul>

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4. Clinical nurse practitioner from one of the clinics	Upset regarding the health-seeking behaviours of the people of Gusi who bring all illnesses, including those that could be classified as minor health illnesses to the clinic even illnesses. According to her, the people of Gusi are going to lose their IHK for the management of minor health illnesses within the home situation.	<p>where power lies. Demonstrated the impact of selective PHC. (10-13)</p> <ul style="list-style-type: none"> <li>• New awareness about emerging health-seeking behaviour.</li> <li>• The confusion between different levels of care for conditions.</li> <li>• The placing of blame approach on both the providers and the consumers of biomedical health.</li> </ul>
5. Chief	Narrated stories of benevolence of older chiefs, in terms of which they would visit a younger chief to monitor how he is doing. He would be expected to slaughter cows for his distinguished guests. However, then the paramount chief, after they had left, would send cows to replace those that had been slaughtered.	<ul style="list-style-type: none"> <li>• Old traditions might appear rigid, like those of the older Xhosa women.</li> <li>• The underlying factor was the need to role-play skills.</li> <li>• It appears that the choice lies in the backward and forward motion - as the Chieftain suggested in the community entry. (14)</li> </ul>

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#### 4.6 CONCLUDING STATEMENT

The demographic details of participants, the issues emerging from the FGDs, as well as the in-depth interviews with the elite older Xhosa women and their family members, all provided insight into why the older Xhosa women were consulted when a family member was ill. The exploration of health and illness with the older Xhosa women showed that they carried a wealth of information regarding health and illness, and how they defined this for their villages. The data gleaned allowed for some interpretation of what was happening regarding health and illness across the 18 villages of Gusi, with distances from the PHC service appearing to have a major impact on the health-seeking behaviour of the inhabitants. The critical incidents showed the complexity of the changing times in which the older women found themselves, and how this tended to increase tensions between themselves and the younger generation, who were influenced by modern influences. This was further endorsed by the transitional opportunistic conversers. However, the circle of care and support that they created, and in terms of which they provided for one another, gave the older Xhosa women a myriad of attributes and skills that are still relevant to the younger generation today, as is shown in the

case studies of the family members of the elite older Xhosa women and in the reverence that they have for these older women. To ensure the relevancy of their role of being the person who is consulted when a family member is ill, including that of the other caring roles that they play within the home situation, the older Xhosa women will need, in future, to adjust their skills to fit in with the changing times.

## CHAPTER 5: DISCUSSION OF FINDINGS

### 5.1 INTRODUCTION

This chapter is a discussion of the results that were presented in Chapter 4. The discussion will start with a description of the critical issues that emerged from the demographic details and the contextual and health-related factors influencing the management of health problems by the older Xhosa women participating as the primary study sample. This will be followed by a discussion of key issues that emerged from a definition of the concepts of health and illness, as understood by the aforesaid women.

Key issues that emerged from the health problems that the older Xhosa women managed at home will then be discussed, as well as will the steps that they took to reach a conclusion that a person/child had a specific health problem. This will be followed by a discussion of the steps and the management strategies that the above-mentioned women used at home to deal with health problems.

A closer examination of the responses of the older women to critical incidents, and whether the incidents influenced the decision-making of the older Xhosa women using IHK in the management of health problems in their home situation will be presented. The rationale that led to the older Xhosa women relinquishing health management strategies at home and referring people with a health problem to an outside source will be explained. Critical research findings that emerged from the study will be presented. A few direct quotes from the participants will be used, not in the form of repetition of findings that were presented in Chapter 4, but in order to illustrate and to emphasise a certain crucial point.

Reference to the primary study sample includes reference to all 36 older Xhosa women in the four FGs. The presentation of findings according to the distances of the clusters of villages concerned from the hospital is done to highlight the impact of such distance on the management of health problems by the older Xhosa women. Reference to secondary samples will only be used to validate the findings of the primary sample. It is also important to mention that, though the current study concerns the health problems that are managed by the older Xhosa women within their home situation (3), the older Xhosa women situated the main research question of the study within a broad understanding of the PHC approach (11,12). They resisted confining the health problems that they managed within the home situation to mere discussion of a disease (12,13) and its management, as they saw a strong link between the disease, the context in which it occurred, and the personal factors concerned.

## 5.2 DEMOGRAPHIC DETAILS AND THE CONTEXTUAL AND HEALTH-RELATED FACTORS INFLUENCING THE MANAGEMENT OF HEALTH PROBLEMS BY THE OLDER XHOSA WOMEN

The following demographic details of the main study sample, the contextual issues that emerged from the study, and their influence on the IHK possessed by the older Xhosa women, as well as the perception of the health status of those living in the 18 villages of Gusi, from the point of view of the older Xhosa woman, will be discussed.

### 5.2.1 Critical issues that emerged from the four FGs

This section contains a description of the process of the integration of the older Xhosa woman into their households. The method of how the IHK possessed by the older Xhosa women was developed and spread amongst the Amabomvane people is outlined. This is followed by an explanation of the educational status of the older Xhosa women. The family status of the households of the older Xhosa women is given, as well as is a description of the impact of the migration of the younger generation in search of work in urban areas. This section ends by describing the contribution played by the age status of the older Xhosa women in them acting as the custodians of the culture of *ukuhlonipha*, which contributes to the health of the home.

#### 5.2.1.1 *The process of the integration of the older Xhosa women into their households*

In Xhosa culture, the *umzi* (home) is the religious unit that harbours and protects the family concerned from birth to death. Within its safe confines, all of the rites of passage that are necessary for satisfying the ancestral spirits of the homestead are performed. (30,43,44) It appears that the older Xhosa women entered the *umzi* of their husbands through arranged marriages (*ukuthwala*), with them, initially, not being used to their partners, for whom they had been chosen, as one woman explained:

*To be a woman is to be chosen by a specific man from a specific family (umfo kabani) wanting you. You are taken from your home and brought to his home.*

At the beginning of a marriage, the young woman would most likely be afraid of her husband. The mother-in-law then had to support the young woman in becoming acclimatised to the household and to the demands of her husband:

*You are taught at home; we are marrying you to that household. You do not even know this person to whom you are being married. You look at his face; his face looks huge. It is to lie down with a man. You start having sexual relationships with him until you are pregnant, and the whole aim was that you must give birth, because, once this happens, you are sealed to this household.*

The above statement suggests that, from the very onset, husbands aimed to impregnate their new wives, as a form of sealing them into the household and the relationship, because, according to the Xhosa custom, once a young woman had slept with other men and became pregnant, she was like 'used goods'. Hence, the new husband needed to seal the relationship with a pregnancy that was clear proof that he had slept with the young woman and that she was 'damaged goods', so that she would be prevented from running away from the arranged marriage. Also, the fear, on the woman's side, of having fatherless children further contributed to the husband wanting to make his young wife pregnant. Such a situation meant that, even if she did not like her husband, her chances of marrying into another household would be minimal. It appeared that seeing that your daughters were married off was an achievement for a household, as the marriage exchange ensured the supply of *lobola* (consisting of cows, horses and sheep), which were brought to the young woman's household by her suitor's family. For such a reason, what appeared to make a young woman attractive to a man (i.e. her virginity) was guarded by her parents in order to ensure that she had good prospects of marriage. Wealth in Bomvane and other neighbouring villages is still measured in terms of land and stock (whether cows, horses or sheep), even up until the present day. (30) Ultimately, most women settle into their households, and even fall in love with their husbands, as is shown in the statement below:

*You fight a lot with this person, until ultimately you do fall in love with him. In the beginning, you do not know his smell - it irritates you; then, later, you fall in love with this smell, and you become jealous.*

From the above statement, it appears that, for the older Xhosa women who participated in this study, when they were young, the above process was accepted as the method that was adopted when marriages were arranged, and as the means by which, as young women, they were integrated into their new household. It appears that the practice was still applicable in the 18 villages of Gusi at the time of the study. Young brides fell under the care of their mother-in-law, which started with the former observing the latter as she supported and integrated the young woman into what, effectively, was her new household. The young woman involved would later play the same role for the wife/wives of her son/sons. Those who were integrated into households that did not have a mother-in-law (i.e. in which the mother-in-law had passed away) saw her absence as a problem for the health of their children, as well as for their successful integration into the household, and lamented the situation, such as in the following way:

*Here I gave birth to a very ill child, my second-born child. The child had stomach problems. I went back home (note that this return home was to connect with the maternal mother). If my mother-in-law was around, she would have helped me.*

Those women who integrated into households with no mother-in-law felt that they could not question what other people were doing in the village, as they had nothing to which to compare the evolving situation and, as was mentioned earlier, the women concerned were married young to men living in villages in which they were not born. Each village had norms and standards, as well as a culture, which varied from other villages, so that they could not duplicate what was done in their maternal home. The statement below supports this:

*Because I did not have a mother-in-law, I had to accept what was done for me, but then I had to learn from experience.*

Not having a mother-in-law who was a grandmother had its own advantages too, as the women had to grow up into their role as a wife quickly, and had to learn, so that they could fulfil dual roles: that which was supposed to be played by the mother-in-law, as well as that of being a wife to their husband. The older Xhosa women believed that the preparation for the roles that they played started from early childhood, when they were girls in their maternal homes, which was validated and finalised in their marital home by the mother-in-law.

The lack of space and time in which to practise your vocation of looking after your home as a married woman, which the older Xhosa women regarded as walking parallel to womanhood, is what they believed brought illness into the home. Once a woman is absent from the home, they believed that the home collapsed, and that illness entered the home. According to the older Xhosa women, women were the carers and gatekeepers of the health of the home (3,60), and, when you were being married to a man, the main purpose of such an exercise was to go to learn under the tutorship of his mother how to look after him and his children, as well as anyone else who was in the house and beyond in the village - in total, the process amounted to ensuring the maintenance of the health of the home.

It is also unclear how long the older Xhosa women would enjoy the status of supporting the daughter-in-law, who was the central person in observing the skills and in silently practising them (40) in preparation for when she herself assumed the role of being an older Xhosa woman. The usefulness of the role was already starting to be questioned as being inhibiting and controlling by some daughters-in-law. Currently, some left the older Xhosa women alone, so that they could go to work in the urban areas, as some of the husbands did not return after leaving home to work in the cities, while some of the daughters-in-law died of HIV/AIDs. A generation gap was, consequently, left, with the grandmothers having no one

with whom they could validate their health knowledge to ensure that the newcomer would fill their position once they died. (3,7,8) The result was a gap in terms of how the health knowledge would be retained.

**5.2.1.2 *The method of how the indigenous health knowledge carried by the older Xhosa women was developed and spread amongst the Amabomvane people***

It is important to note that none of the women was married into the same clan, and that the majority were born in villages outside of Gusi, and only came to Gusi in order to marry. The Xhosa people organise themselves in clans, with, over and above their name and the surname that they have linking them to their father's surname, a clan name, which links them to their father's clan. Such a system ensures that all villagers are always linked to a household, hence it is perceived that one rarely finds homeless people in Xhosa villages, due to said design. (60,158) In the past, marriages were not allowed to take place between members of the same clan, for fear that it would disable families. (30,41,42)

It could be expected, then, that even in other villages outside Amabovane, the same pattern of young women moving from their own villages to be married in other villages was the norm, as the Xhosa tradition tended to see all children from the same village as belonging to all village households. In addition, villages were, most of the time, arranged in clusters of clans, and one was not allowed to marry somebody from the same clan.

When one observes the growth pattern of the young girls in their own villages who are tutored in health issues by their maternal grandmothers, and who later marry into another village and who fall under the tutorship of the mother-in-law, one can observe a cyclic pattern of IHK moving from one generation to the next and from one village to the next. The IHK is entrenched in a Xhosa woman as she moves through the various stages of development of being a grandchild, a young woman, a daughter-in-law who will soon be a mother, and finally a mother-in-law (with the process possibly including transferring a herb from one's own maternal village to the village into which one marries). The mother-in-law validates, approves and adds to the health knowledge possessed by the daughter-in-law, as she, too, bears her own template from her own grandmother and mother from her maternal home, as well as from her own mother-in-law. It appears that this is how the IHK for the management of health problems within the home situation was developed and shared amongst the villages of the Xhosa households and the Amabomvane tribe. (7,8,30) However, the breakdown of family units caused by the movement of younger people to seek work in urban areas meant that the cycle would, ultimately, fall away.

According to the women surveyed, for a person who was born in the Gusi villages, there was a herb that was readily available to manage each illness; it was only illnesses that were brought by outsiders for which no herb existed. The hospital was seen as an outsider by the older Xhosa women. They sometimes admired it for its provision of biomedical care that appeared to save their families, but then blamed it for not providing solutions for what they perceived as new illnesses. It appears that, for the health care service to regain its acceptance among such women, the service would have to move away from rendering only selective curative PHC (11,13), and a comprehensive PHC strategy would have to be devised that addressed the social determinants of health through health promotion and disease prevention programmes. (12,13)

### **5.2.1.3 The educational status of the older Xhosa women**

It appeared that the young men of the Gusi villages chose marriage partners who had no schooling, as, in each of the FG discussions, the majority of the women present had received no formal education. This had both a positive and negative effect with regard to the impact of Western education on the people of Gusi, as the young woman (i.e. the key person whose health knowledge was required to be validated by the mother-in-law) would bring mainly a culture that had not been influenced by Western culture from her own village to strengthen the Amabovane culture that, too, had been minimally influenced by Western culture.

As was mentioned in Chapter 1, in Bomvanaland education had managed to polarise the Amabomvane people into two groups: (a) the 'red' illiterate people (*amaqaba* = people who painted themselves with red ochre and who were traditionalists); and the 'school' people (*amaqhobhoka: abantu basesikolweni* = people who had left the traditional life, who were usually Christians, and who were, to some degree, westernised). (58) The four FGs were mainly dominated by *amaqaba*. The women concerned, who mainly lacked a formal education, were not only expected to carry the cultural identity of the Amabomvane, but were also expected to facilitate the development of such identities amongst the third generation.

The above has had a far-reaching effect with regard to the retention of the cultural identity of the Amabomvane, as well as with regard to the IHK possessed by the older Xhosa women. This meant that the IHK was still conserved, and that its rigour and testing were still enclosed by, and mainly tested amongst, the Amabomvane people. Under the prevailing conditions, the above also implied that the older Xhosa women would be less likely to openly receive and understand the benefits of biomedicine. Unlike biomedicine, which has a claim to being subjected to scholastic rigour in the form of testing, research, writing and publication, the IHK carried by the older Xhosa women lacked such a status. (7,8) First, the older Xhosa women mainly spoke isiXhosa and lacked the English tools required for receiving and understanding

biomedical health knowledge. In contrast, it was difficult for them to explain to health professionals either what they used or their rationale, including the dosages that they had used, in terms of acceptable measuring systems, like the metric system. Instead, they shied away in silence, while there were clear signs and symptoms that there had been some other intervention that was used before the person was brought to the health facility.

The silence of the older Xhosa women and the blame that emerged from the health professional with regard to how the older Xhosa women had taken a far simpler health condition, and perhaps complicated it by using IHK, put the patient at risk, as she/he still had to return home, where he had to conform to the instructions that s/he received in his/her home in recuperating from the illness. (3,18,19) A way of communicating needs to be found between the two spheres of biomedicine in the 18 villages of Gusi and the IHK possessed by the older Xhosa women, beyond the challenges arising from the lack of formal education of the older Xhosa women, for the benefit of the health of the patient. The management of the health problems of the people of Gusi can only be comprehensive, and can also only grow if such channels of communication open up. Such researchers as Durie (46), Posey (47), and Palafox (116) have expressed concerns about the split between IHK and health care from the Western world, which they foresee as having poor health outcomes for those requiring the assistance of health services. In addition, Broad and Alison (117) are calling for an alliance of respect between indigenous healers and those coming from the Western world approach to health care systems.

#### **5.2.1.4 The impact of the migration of the younger generation for work in urban areas**

Cook (1973b, in Jansen (30)), in writing extensively about the education of South African tribes, expresses a concern about the lack of vital connection between the schooling and the life of the tribal community. Many of the younger people were found no longer to be wearing *imibhanco* (i.e. the cultural red blanket that is traditionally used as a dress) and, once they completed high school, they had to attend colleges that were outside Bomvanaland, as the following extract explains:

*There was a time there was work in the villages, and children were not moving. This time, the child leaves, saying he is going to seek employment. There is still slavery, we are complaining to the children.*

As was earlier explained, the Amabomvane tribe was an arrogant tribe that were brought to their knees by poverty and hunger. They saw themselves as having an equal relationship with the Europeans, who arrived in what they regarded to be their land via wrecked ships. The breakdown of the tribal economy redirected the Amabomvane culture towards a path of

rapid cultural change. The start of industrialisation and migrant labour had a severe negative impact on Amabomvane life. (30)

The older Xhosa women saw the above as a form of slavery, as their children left to work in the cities during their most productive years, with some not returning to their original homes. (30) In addition, those who did return were alienated from their cultural identity that required the wearing of traditional clothing, and from village life that required all to work hard, as there were large families to feed, as can be seen in the following statement:

*As you know, we are the people of the red blanket; we are not like the people from the urban environments. In town, you open the tap, use electricity; everything works hard on your blood. Here, groceries get finished before time. You must dish up for everybody.*

From the above extract, one can see that the older Xhosa women thought that life in Bomvanaland was different from urban life, with the former being more difficult, as they lacked such amenities as electricity and tap water that were used in urban life. Such amenities are at the core of PHC, and should be facilitated by the primary care service point, such as the clinic, that is nearest to people's homes. (10,11) However, when asked whether they preferred a village or urban lifestyle, they seemed to be uncertain. In contrast, the older Xhosa women from FG2 said that they thought that introducing running water, flushing toilets, electricity and jobs to the area would improve the health status of those living in the 18 villages of Gusi. It appeared that it was not a matter of choosing between village and urban life, but that there was, among the women from FG2, an urgent need to improve the status of health in their villages by bringing certain amenities that were similar to those that existed in the urban areas, and which they regarded as being essential for the maintenance of health in their villages and also being part of their rights as South African citizens. (10,11,18, 159) The plan to revitalise primary health is commended, as doing so might help to satisfy the, as yet, unfulfilled promises of 1994, by improving access to PHC, especially in the rural areas. (18,160) It is hoped that doing so will include the opening up of job opportunities for the village youngsters, so that they will not feel compelled to move to the city. (10,11) A good place in which to start would be to assist said young adults with opening up boreholes and with laying on running water for their villages, as well as with erecting toilets for their village homes.

The above implies that, for the majority of the time, the women were on their own and that, when somebody was ill at night, they had to wait until the sun had risen, as it was not customary for women to move around at night. (30) Such customary behaviour meant that, when a person fell ill at night, the older Xhosa women had to try any means possible to

alleviate the illness. Accordingly, for the current home-based study, categorising the health problems that were managed by the older Xhosa women as minor health problems has been a particular challenge. (3,19). Part of their rationale for managing health problems, including those that can be classified as complex, was related to difficulties with accessing public health services (160), whereby the older Xhosa women might have found themselves having to resort to using whatever was available in the home in order to assist the ill person. (18) The situation is still prevailing in the 18 villages of Gusi, especially as far as those who are farther away from the hospital are concerned.

Those who are close to the hospital, which is a 24-hour health service, accompany their ill relatives there at any time of the day. Some relatives who live at some distance from the hospital bring the ill, especially those who have been having a difficult pregnancy, to stay with relatives who are living close to the hospital. A positive point is that the majority of households have mobile cell phones, so that the member of such a household can call for an ambulance at night to pick up a ill relative. The challenging issue is that there are no ambulances at the hospital. The nearest ambulance is that of Walter Sisulu, which is a referral hospital in Umtata, which is 2 hours away from the district hospital.

#### ***5.2.1.5 The family status of the households of the older Xhosa women***

Out of 36 women, the husbands of 12 women, of whom eight were from FG3, were still alive. The husbands of those in FG3 had stayed at home to assist the chief in his leadership role in the village. The chief himself was already over 80 years old. The wife of the chief and some of the women from FG1-4 were in polygamous marriages. Being in such a marriage had both positive and negative outcomes, as, on the one hand, the wives appeared to develop sisterly friendships and to battle the challenges of married life together, as many husbands left their wives and homes to go and work in the mines in the urban areas. (30,43)

On the other hand, husbands were open to marrying single women who, once they entered into a polygamous marriage, tended to compete for the attention of the husband. This left the older wives isolated, as was shown in critical incident 5, and this did not always strengthen the home. The highest positive determinant of health is a household that functions harmoniously, with minimal in-fighting and squabbles. In critical incident 5, the wife of the chief believed that her loss of sight was caused by the chief marrying his younger wife in a manner that was different to that which was prescribed by the cultural customs of the 18 villages of Gusi.

The above incident again refers back to the Amabomvane being conservative about their culture and, in the said instance (30), the situation was working positively for the first wife of

the chief, as they continued to integrate her into her role as a key role-player in village life. So, somehow the villagers intervened to re-establish the health status of both the house and the village, even if the incident was about teaching the chief of the village a lesson about respecting the cultural norms of the village that kept the health status of the village intact.

The issue of polygamous relationships has become a contentious issue with regard to women's rights advocates in South Africa, as the country tries to achieve equality for all (in terms of the South African Constitution). Arguments exist, such as, if South Africa, as a country, allows young women to enter into polygamous relationships, then women should have the right to have as many husbands as they want and like too. It appears that said issue is being discussed in the more modern forums of South Africa, with the inhabitants of the 18 villages of Gusi being encouraged to discuss the relevancy of the tradition in their villages, too, to see whether there is room for refining the polygamous culture to ensure that the rights of all are thereby upheld. (159)

The women were noted as having large families, including, on average, seven children. Maleana has already explained how important giving birth is to the African family. (43) As has previously been explained, Amabomvane still uphold their culture. Again, having a large family could be interpreted as a sign of prosperity, because the children support the family by performing duties that build up the home (such as helping with the ploughing of the fields and ensuring that cattle, sheep and goats go to the grazing areas with grass, and are not stolen by stock thieves). (30,43)

Out of 224 children born to participants in the study, 86 had died, of which the majority had died from diarrhoea-related diseases, from which they had suffered between the ages of 1-5 years. (11,12) When the researcher shared her concern with Sister A during the transitional opportunistic conversations, arguing that the occurrence of such disease was due to the lack of running water, Sister A disagreed with her. She seemed to think that the cause of the disease was bottle-feeding, and that the women lacked the hygienic measures required for such feeding. Earlier on, it was explained that, with selective PHC,(11,13) the mothers of children from developing countries were encouraged to supplement their breast milk with bottle milk, as UNICEF argued that to expect mothers with malnutrition to breastfeed continuously was a challenge. (11,12) The strategy that would appear to be more suitable for the 18 villages of Gusi would be to assist mothers in meeting their nutritional requirements, and in continuing to breastfeed their children, with all of its associated benefits. At the core of the adoption of such an approach would be the Alma Ata Declaration's promotion of the role of primary care services in fighting poverty and in food production, thereby helping to ensure that the mothers could fully breastfeed their children without having to resort to bottle-

feeding. (11,12,13) Hunger, poverty and the lack of good nutrition have already been highlighted as a problem by all of the FGs. The revitalisation of PHC should come to regard the revival of food production through the ploughing of the fields belonging to the 18 villages of Gusi as a priority. (160)

**5.2.1.6 Age necessitated that the older Xhosa women were the custodians of the culture of *ukuhlonipha* that contributed to the health of the home**

All 36 older Xhosa women were older than 60 years. They were mainly married and belonged to the first generation (grandmothers) of women of the 18 villages of Gusi. At home, the older Xhosa women were expected to be in charge of health matters, especially in regard to ill children. (58) The mainly paternal grandmothers played an authoritative position in their kraal, and gave instructions as to the type of health care to use in, and sometimes beyond, the home, thereby assuming the roles of elite older Xhosa women (see definition of terms, p. xxiii). (30) They were also expected to teach and to manage the culture of *Ukuhlonipha* (respect).

*Ukuhlonipha* is an important integral component of health that assists in keeping the harmony of the village and in preventing in-fighting, as each person listens to the others, and disputes are resolved in a negotiated fashion (30), which is safeguarded by the older Xhosa women. The younger generation within the home is taught by the older Xhosa women about how to follow rules and regulations, as well as about the culture of the Amabomvane. Broken-down relationships, according to the indigenous way of life, cause ill health, which, when it sets in within the home, the older Xhosa woman is required to manage as part of the health problems within the home situation, thus expanding her role. (7,43) Lack of respect, especially amongst children, and in-fighting are regarded as unhealthy states of mind, and are deemed to bring illness first to the home and then to the village (7), as, according to the older Xhosa women, ill homes result in ill villages.

The 18 villages of Gusi still uphold their conservative tribal approach of collective decision-making by the villagers. (30,43) *Ukuhlonipha* is initiated by the older Xhosa women for honing the grandchildren further during village interactions and rituals. A household that has respectful children and adults is envied by the village, with such children somehow becoming a yardstick that other parents use to measure the behaviour of their own children against when they are trying to convince them to be respectful and to conform to the cultural norms and standards of village life. Each household wants to contribute to the collective spirit of the village life, with respectful children and adults having been taught well about the cultures of the Amabomvane, and thereby helping to uplift the health status of the village concerned. The right outlook would result in the older Xhosa women having sufficient time to engage in

conversation and to share with other older Xhosa women regarding other matters in respect of building up the village, as they would then be dealing with healthy homes and villages. (30)

When the older women were growing up, no police systems impacted on the villages, and, even at the time of the current study, the nearest police station was in Elliotdale, which was an hour's drive away from the 18 villages of Gusi. The chief was the main person who was responsible for resolving village disputes, with which households assisted him, by ensuring that they had stable households, where there was little quarrelling and in-fighting. Some of the aspects of the culture of *ukuhlonipha* are tipped towards respecting the man, with a married woman somehow being regarded as a visitor to the home, as she comes from another village, so that she might not be conversant with what the men of the village see as the behaviour of a respectful woman. (30) The grandmother, who is also a mother-in-law, teaches the culture of *ukuhlonipha* to her daughter-in-law regarding how to respect her husband first, and then the men of the household, as well as the relatives and visitors from the village. Older Xhosa women uphold such a system, in order to ensure that harmony prevails between the daughter-in-law and her son, and that the household remains a healthy household, which reduces the burden of responsibility on them as the custodian of the health domain of the household.

Adjoining the hospital was a beer hall that appeared to upset the concentration of the older Xhosa women in FG1. According to the chief of Gusi (see Chapter 3), alcohol drinking was a grave problem for both young and old in the area. He seemed to think that such drinking was impeding the progress of the villages, and that it had a significant negative impact on the three aspects of the Gusi villages discussed below.

Firstly, he held that the attendance of younger people, especially of young men, at beer halls had a negative impact on the production of food, as they left the beer halls in the early hours of the morning drunk and tired, and in no position to prepare the cattle for ploughing the fields. Preparing cattle for ploughing the fields usually happens between 4 and 5 a.m. (30,60) Starting work so early assists the youngsters to finish the chore in time for those who are still attending school to prepare themselves for the day ahead. Both the ploughing of the fields and the attending of school are not possible when the young people are drunk from beer halls in the early hours of the morning.

Secondly, the chief also saw the youngsters as being vulnerable to the spread of HIV/AIDS, as he believed that, when the young people left the beer halls drunk, their capacity to make

the correct choices about with whom and how they should have sexual relations was undermined. (43)

Thirdly, beer hall attendance cuts deeply into the Mbovane culture, according to which respect is seen as an integral component of the Gusi village and of the lives of members of the Amambovane tribe - the older Xhosa women described the upholding of respect as being a determinant of health, with the young respecting the old, and the old respecting the young. The chief believed that older and younger people drinking together in beer halls undermined the tradition of respect, because, when drunk, a youngster feels capable of verbally disrespecting an older person, and an older person can act foolishly in front of the youngster. (30)

Lastly, a component that the village chief did not mention was that there was a group of older Xhosa women who had been left alone with unruly grandchildren who started abusing alcohol and drugs. The older Xhosa women struggled to look after the health of the home, as, most of the time, they had to try to contain the problems that were caused by the unruly grandchildren. Usually, either the mother or the father had died of HIV/AIDS and the grandparents had to assume the parental role. Sometimes, the husband left home to find work in the city and failed to return, as he developed other relationships in the urban setting, and the wife had to relinquish supporting the older Xhosa woman in looking after the health of the home, as she, too, needed to go and look for work in the city.

Abusing alcohol and drugs can only impact negatively on the tapestry created by the blending of the Amabomvane sense of harmony and stability that the older Xhosa women saw as one of the determinants of health. Such a situation implies that the type of illness that was experienced by both their children and grandchildren, such as drug abuse, alcoholism, TB and HIV/AIDS, with which the older Xhosa women were faced in their home situation was far more complex than were the illnesses that the older Xhosa women perceived as being remediable by means of a readily available herb. For managing some of the socially related illnesses, the older Xhosa women lacked both the required skills and resources. The result was that they blamed the hospital that they perceived as intruding on their previously harmonious existence by bringing new illnesses into the villages of Gusi. (30)

### **5.3 DEFINITION OF HEALTH AND ILLNESS, AS UNDERSTOOD BY THE OLDER XHOSA WOMEN FROM THE EASTERN CAPE**

This section covers the discussion of key issues that emerged from defining the concepts of health and illness, as understood by the older Xhosa women in the four FGDs. The data from all four FGs were combined to present a comprehensive overview of how the older Xhosa

women defined health and illness in their villages. Key issues linking the four FGs to the distances from the hospital were also highlighted.

### **5.3.1 Key issues emerging from the definition of health and illness**

The WHO defines health as “(a) state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. (45) The definition is not far off from how the older Xhosa women defined health - except that they appeared to add extra components, including issues of food security, healthy children and families, and peace and security in their villages. According to the older Xhosa women, health and illness should be seen from within both a physical and spiritual context. They further saw health as important and that, without health, there could be no progress in the home. Worry was seen as the greatest negative contributor to ill health, with troublesome men and children being the greatest cause of worry in their situation.

The older Xhosa women described health from both a positive and a negative point of view (as the presence of health and the absence of disease, and vice versa). It was noted that the older Xhosa women from the villages that were closer to the hospital appeared to describe health from a deficit perspective (in the form of the absence of health and the presence of disease), which implied that their focus was on disease, with the main aim of curing the disease, rather than on obtaining wellness. (11,13) Those who were farther away from the hospital appeared to describe health from a wellness and stable family perspective. All four FGs seemed to see the general state of health in the villages as being bad, as all the determinants of illness and ill health, such as diseases like HIV/AIDS; the absence of amenities, such as of projects concerned with creating employment opportunities; and hunger, as well as unruly children, were clearly present. (12,31)

General disillusionment with the government was expressed, with it being seen as introducing new methods of food production (like tractors) (15,18,19), rather than relying on the more traditional methods of ploughing using cattle, and as fencing in the ploughed fields. All the newly introduced amenities were seen as requiring maintenance, as tractors tend eventually to break down, and fencing ultimately requires repair, in which the government seemed to lack interest. It appeared that the imported livelihood creation and health maintenance strategies were considered problematic, especially in terms of them lacking sustainability. Hence, at the time of the current study, the idea of reverting to the methodologies that were used by the home to produce food and to maintain health seemed preferable, in the light of the perception that the home was the source of true help. A stable home and family was seen as an important contributor to health, which appeared to be hanging in the balance, as families in the area were struggling to maintain such stability. The

children were unruly, and the alcoholism of both the young and the old was taking its toll on homes in the Gusi villages. On an ongoing basis, the responsibility of looking after the health of the home, with which the older Xhosa women had been tasked by the patriarchal structures of the village, appeared to be difficult to meet and elusive.

Again, the government appeared to have intervened insufficiently, as parents had been informed that they could not beat their children as a form of discipline. However, the government had not offered an alternative method of how to deal with unruly children. Instead, the government had threatened parents who inflicted corporal punishment on their children with imprisonment. To sum up the situation, according to the older Xhosa women, the current government was not seen as making a positive contribution to health in terms of the following two important health indicators:

- failure to bring about stability in terms of the production of food, which was seen as an important contributor to the health of the home; and
- interference in the parent-child relationship amongst the villagers. Instead, the government had introduced an education system that failed to prioritise and to contribute to positive social health determinants. The positive determinants concerned were regarded as being peaceful villages that could produce sufficient food, and within whose environments children could be taught how to be a Bomvane, with proper reverence of the ancestors being one of the uppermost functions. (93,95-97,100) Due to the inadequate government intervention, the children tended to leave the village after schooling, further deepening the plight of the village with regard to any possible progression in producing food for itself (30, 43, 44), as well as deepening the prevailing education gap.
- To aggravate the situation still further, the government licensed beer vendors in the village, thereby exacerbating the plight of non-production of food and undermining the most important value of the village - that is, *ukuhlonipha*.

Children's health, starting with healthy women who were capable of conceiving and bearing healthy babies, as well as the healthy development of the child, was seen as contributing positively to the health of the village as a whole. Such thinking was not far from that of providing selective PHC. (11,31) To have healthy babies, the older Xhosa women held with starting with healthy women who resided in the peaceful villages that produced sufficient food, so that they could carry their babies in healthy bodies that were fed until they reach satiety. To ensure the continuance of such health, implementation of a comprehensive PHC strategy is required. (12,13) Support of the development of the child was seen as everybody's duty in the village, but especially as being that of women, which was seen as

making a positive contribution to health. The children, in turn, were expected to assist in building up the home and the village when they were adults, and not to leave for the urban areas. Being able to produce food and to feed the family until they reached satiety was seen as a positive health contributor, while buying food was seen as having a negative impact on health. It is understandable that the issue should have been seen as problematic by the women concerned, as food itself was interpreted as a herb, and when one ate food from the soil that one held and that had been fertilised by the afterbirth of one's mother, according to the older Xhosa women, healing was promoted. Also, during the cooking of the evening meal in a big three-legged pot on a fire inside the hut that was used as a kitchen, the grandmother sat alongside the fire for warmth, and the grandchildren nestled next to her, listening to bedtime stories. Some would fall asleep without having received the evening meal, which they would then eat the following morning. The older Xhosa women saw such a lifestyle as promoting health and their healing skills and attributes. (94,95)

The peace and happiness that comes from families not fighting, from them producing enough food for all their members, and from them being supportive of one another were all aspects that were viewed as being key contributors to wellness. According to the older Xhosa women, no one in a healthy mental state would cause in-fighting and instability within the family and the village. In-fighting was seen by the women as a lack of health, and as a cause of disease, which was in contradiction to the Amabomvane culture of *Ukuhlonipha*.

Possessing a belief in God was also seen as being critical to wellness. Buhrmann explains the relationship of Xhosa people with God by highlighting that, although there is the misconception that Xhosa people worship their ancestors, that is not the case. Xhosa people revere their ancestors, who are seen as the link between God and the living - they are seen as intermediaries between God and those who are still alive. (30,43,44,93-98) This was the case for the older Xhosa women from Bomvanaland - they had ancestral reverence, and their ancestral connection assisted them when their health strategies were not helping, as, usually, the ancestors, who might have been the previous grandparents who had assisted in validating their knowledge, came in the form of a dream, instructing them regarding where they might find the correct herb for a ill person. To them, to have ancestors on one's side was good for the health of the home, and helped to facilitate the maintenance of the health of the home, as they felt supported and guided by their ancestors in promoting such health. (30,95)

The above might also have been another source of mistrust regarding the hospital that was built by missionaries who brought Christianity to these parts. The ministers, who mainly practised their belief from out of an orthodox perspective, nullified and ridiculed the ancestral

beliefs held by the Amabomvane people. (30) According to the Mabomvane, Christianity not only deprived them of meaningful contact with their ancestors, but also deprived them of their relationship with God, as the new religion that had brought modern health services to Bomvaneland failed to recognise the Bomvane people's use of ancestral reference as a way of connecting with God. (93) Without ancestors, there was no link with God. It appeared that the participants believed in the same God that the ministers from the Dutch Reformed Church believed in, with the difference being how to link with the God of their faith. For the Bomvane person, such linkage was via the ancestors, whereas, for the traditional Christian believer, the linkage appeared to be direct. (93) The issue appeared to be a thorny one, which had caused a disjuncture and a lack of trust between the Amabomvane people and the hospital and its health care professionals. The older Xhosa women sometimes, in desperate times, when a relative was ill, and they had taken that person to the hospital, were unsure that the person would come out of the hospital alive - they used to say that they had taken the person to God. The prevailing mistrust might explain why they 'borrowed' a person out of the hospital to take to a traditional healer once they perceived that the hospital care was not assisting the person to heal. The ultimate intention was to prevent the ill person from dying, as the hospital was seen as the last health care provider before death. The different prevailing belief and cultural systems still required to be understood by the health professionals in the area. It appears that, for the Bomvane person, without connection to the ancestors, one's health status is not balanced, hence illness is a symptom of the imbalance concerned. Even if one were to be restored to health by means of the use of the biomedical approach, as a Bomvane, one needed to return home to conduct a ritual to thank the ancestors for supporting one's recovery and to make a pledge to them, in order that they might continue assisting one with one's health status, so as to prevent one from relapsing. (58,93-98)

With regard to what undermined their health, the older Xhosa women from FG4 believed that not being able to make their own Xhosa beer had been deleterious to their health. To make Xhosa beer, one ferments porridge made from a plentiful supply of ground maize. The ability to make Xhosa beer indicates that families have enough maize to feed themselves, and, hence, they wish to thank the ancestors for a good harvest by making Xhosa beer and drinking it, which serves as a connection between the two, and which also serves to express the reverence felt by the families to their ancestors. It is important to note that the households of the area in question had gradually stopped producing Xhosa beer, which could have been a sign of them not producing enough maize. Also, of the daughters-in-law who traditionally assisted with making Xhosa beer, some were dead and others had left to work in the cities. Usually, Xhosa beer required somebody younger to make it, as it required

much strength to make. The above had grave implications for the status of health in the villages, as food production was mentioned as one of the determinants of health by the women. Like other foodstuff in the village, traditional beer had been replaced by branded beer, milk stout and other alcoholic beverages. Again, to the women studied, buying any food/drink that they perceived that one could produce oneself was a sign that one's health status had declined.

People nowadays only make Xhosa beer when they are preparing for a ritual. Similarly to balancing IHK and biomedicine, on one side the Gusi villagers bought beer brewed by the South African Breweries, whereas, on the other side, they continued to make Xhosa beer for rituals. It appears that the two systems of obtaining beer coexisted in the 18 villages of Gusi. The externally brewed beer was easily available, and did not require strength, maize and time to make. The change in beer- drinking patterns could have been due to the changes in the times, according to which, in Bomvaneland, there were also other cultures that had brought other civilisations and ways of doing things into the area. (30,43,44) The older Xhosa women from FG1 had already questioned the researcher with regard to the Christian practice of drinking red wine, to which they allude as 'the blood of Christ', and had asked her why they should not drink Xhosa beer for ancestral reverence. Perhaps there will come a time when the families of Gusi will also drink red wine when they conduct ancestral reverence, as producing Xhosa beer could be seen to be becoming a challenging task. The greatest challenge, according to the older Xhosa women, was that those of the new cultures and civilisations wanted to replace the Amabomvane culture (7,8) with their own, instead of studying the latter culture first and *then do(ing) a backward and forward movement*, as had been suggested by the chieftain of Gusi villages. (14,43)

The handful of older Xhosa women from FG1 and FG4 stated that they did not wait for the brewing of Xhosa beer; they simply went to the beer halls to satisfy their needs. The question that needed to be asked was this: Was the drinking of beer from the beer halls still used by the older Xhosa women for linking with their ancestors and for ancestral reverence, or was their drinking part of the alcoholism to which the chief alluded? Many studies have shared concerns about the vulnerability of indigenous knowledge in relation both to the Western world and to charlatans within the indigenous knowledge system. (7,44,97) Whilst the Western world might discard indigenous practices as being outdated (116,120), indigenous charlatans tend to use such knowledge when they want to protect their own actions, which are in contrast with those actions that would assist the situation of the ill person (i.e. they are merely taking chances). (7) It appears that charlatans were violating the cultural practices of women, namely being at home (in the form of the 'hen' and the 'sheep' of the home) and

assisting in the brewing of Xhosa beer for purposes of ancestral reverence. Instead, they spent most of the day sitting in beer halls, which activity they then claimed was a form of ancestral reverence. (30)

#### **5.4 DISCUSSION OF KEY ISSUES TO EMERGE FROM THE DISCUSSION OF THE MANAGEMENT OF HEALTH PROBLEMS BY THE OLDER XHOSA WOMEN WITHIN THE HOME SITUATION**

This section discusses the main health problems that the older Xhosa women were found to manage at home; the steps that they took to diagnose the type of illness that occurred in such a setting; the management steps involved; the critical incidents that influenced their decisions to give up managing the illness at home; and the people to whom they preferred to refer a patient. This section will be presented according to each FGD, keeping in mind that the FG1 was the closest to the hospital, whereas FG4 was the farthest from it.

##### **5.4.1 Focus Group 1: Management of the health problems within the home situation**

FG1 was reluctant to discuss the health problems that they managed at home. When one used the outcomes from the definition of health and illness that the older Xhosa women had given, one could see from their critical incidents that they were faced with ill health in their families, such as with young adults who abused older women, hunger, and a lack of home security.

It was interesting to note that, in the five conditions that they mentioned, TB and headaches were seen as requiring hospital care. With TB, they were able to diagnose the illness progressively from dyspnoea, to difficulty in walking, to haemoptysis. Other illnesses, such as eye discharges and chest pain, were seen as belonging to the home in terms of management. On observing the illnesses that they appeared to be managing at home, the researcher suggested that they formed part of the minor illnesses that could be managed at home. To the older Xhosa women, if the home failed, the traditional healer had to take over, as they appeared to lack the skills to manage the conditions at home.

Maelene (43) remarks that traditional Africans do not believe in chance, bad luck or fate, but that every illness has an intention and a specific cause, and that, in order to combat the illness, the cause must be found and counteracted. In the quest to understand illness, the questions 'Why?' and 'Who?' are uppermost in the minds of traditional Africans. It was perceived that, when the older Xhosa women referred to managing certain illnesses at home, they implied this type of approach. The home, according to the older Xhosa women, was where the relationships that maintain the harmony and the cohesiveness of the village are built and maintained. Ill health was regarded as the result of the breaking down of

relationships. (7,43) When relationships have broken down, the ancestors become unhappy and can worsen the situation by punishing those who have broken the relationships, by causing even more ill health. (95-98) The home is, then, seen as a place in which relationships can be reconciled through the conducting of rituals and the appeasing of ancestors, and even by directly facing the person about whom there is a perception that wrongdoing has been done, in order to ask for forgiveness. (43,44)

According to the older Xhosa women, the above restored the harmony of the home and addressed the problem of ill health. (93,95-98) Indigenous people describe health as an intergenerational issue that aligns the spirit, the intellect, the physical body and the emotions. For ill health to occur, part, or all, of the dimensions might be disturbed. (7,8,43) The African tradition perceives that, in order really to cure the disease, one has to cure the (ultimate) cause of the disease, which concerns the dysfunctional relationships. (43,44) The cause of the disease might be linked to broken relationships, to evil spirits sent by others to one, or to environment-related illnesses. It appeared that the older Xhosa women from FG1 still used said approach in the management of illnesses in their home situation. They allowed the hospital to handle the proximate (actual) disease (43), but took the devising of the ultimate long-term preventative strategy for the home to traditional healers, under whose guidance they would link up with their ancestors for appeasement and the expression of reverence. It was hoped, by doing so, that both the person and the home were sufficiently strengthened so as not to fall ill again. (43,44,95-98) The above was their health promotion and prevention strategy. (82)

It also appeared that, though the older Xhosa women were keen on visiting the traditional healers, they were really unsure of how they cured illness - they just classified the latter as healers. It appeared that the culture of not asking questions was practised in regard to both the traditional healers and the health professionals by the participants in FG1. In the case of traditional healers, as was mentioned above, the older Xhosa women did not ask how they managed illnesses. With health professionals, when they were unhappy about the recovery rate of their hospitalised relative, instead of asking how the relative was being managed, and whether there was any hope for improvement, they took the relative out of the hospital to a traditional healer. Generally, the culture of questioning those in the know was not accepted by the villagers, as the knowledgeable among the Amabomvane people would tend to be the elders. (30) According to the culture, youngsters are generally not seen as carriers of validated knowledge, as such an ability comes with age, due to the amount of space and the length of time that is required for gaining experience. (60) Since knowledge was conveyed by word-of-mouth among the older people, to question them was seen as being disrespectful.

(3,60) As the older Xhosa women from FG1 that was close to the hospital were gradually losing their IHK, the above increasingly became aware of a problem, because the knowledge was not replaced with a new understanding regarding the new approaches of biomedical care. The above presents an element of helplessness and passivity regarding either resorting to biomedical care, or remembering and applying IHK when health problems emerge at home. It also means that the FG participants' gradual integration of biomedical care into the home was occurring quite slowly, as they lacked the tools (i.e. an understanding and interpretation of the English language) to integrate such knowledge into their existing knowledge base. (116)

The impact of the loss of IHK resulted in opting to bring all illnesses, including even those that were classified as minor health ailments, to the hospital. It appeared to be the case in relation to the group in question that they were gradually forgetting how to manage minor health problems at home. In contrast, they were also not learning, in respect of biomedical care, how to manage health problems within the home situation, as they were not questioning how the doctors and nurses managed the health problems concerned, and the health professionals involved did not appear to see it as their principal role to explain to patients how their condition was being managed.

A host of researchers (17,33,70) have already expanded on the pitfalls of the revolving door syndrome that develops with patients of biomedicine when health professionals overlook the component of health care management that involves transferring health knowledge to the patient. When such a patient or a relative becomes ill with the same condition that they have been taught to manage at home, they have the option of trying out first help at home, or of urgently seeking help from the hospital. Mntwana (19), in her study of the health-seeking behaviours of clients in Khayelitsha CHCs, also found a lack of transfer of biomedical skills and management approaches by health professionals to patients who were attending the PHC services.

The cessation of the older Xhosa women from being health managers in the home has had a negative impact on both the home and on the health care facility (3,16-19), as, gradually, the home has come to lose its skill of how to manage health problems using IHK, and it appeared as though nothing was replacing the IHK for FG1 participants. Also, older people were dying, and the health facility would have to manage all illnesses, even those that were classified as minor health problems. (3,19) The middle generation to which the older Xhosa women would tend to convey such knowledge was also dying from HIV/AIDS. (43,72) What was left were the grandchildren with gaps in their health knowledge, as no opportunity was provided for IHK to be validated during middle age. Over and above such a situation, the

FG1 participants blamed the hospital for bringing all illnesses into the area, while they continued to be the consumers of the services provided by the health care institution. The above was problematic, as everyone appeared to be sitting on the fence, with no one being prepared to address the situation as such. (116) The existing situation undermined the growth and development in the management of health problems for both sides concerned, with the losers being mainly the older Xhosa women. Health professionals are fairly mobile (17), so that, if they are unhappy about the status of health services at the local hospital, they can move to other functioning health services. (70) Hence, in terms of said *modus operandi*, the hospital management should ensure that patients find a conducive environment that encourages openness and working together with the patient and their relatives at the hospital. The most important skill that they will need to utilise in doing so will be that of listening to the patient with regard to the approaches that they use for managing their relatives when they are ill within the home situation. The health professionals, in contrast, were responsible for transferring health knowledge and skills to their patients about the first help that they could give to their patients within the home situation, and about when they should bring them to the health service. (10,11,33)

FG1 participants acknowledged the role that was played by other community-based biomedical healers, such as by the general practitioners whom they perceived as possibly having an injection that they perceived to have a stronger effect than did the Panado that was dispensed at the clinics and the hospital. The older Xhosa women from FG1 appeared to be practising their rights of choosing which health care facility to visit (whether private doctors, the hospital, traditional healers, or the clinic), and had their own rationale as to why they visited a healer. Such an understanding is positive respecting the future planning of an integrated PHC model, as the older Xhosa women appeared to be driven by type, the extent of illness, and the approach to a condition used by the health manager (whether the hospital, the elite Xhosa women, the traditional healers, or the general private medical practitioners) in referring somebody outside the home. The challenge was that they tended not to explain to the hospital and its health professionals why they opted to choose for the other health care choices. Despite all the controversy concerning health-seeking behaviour that appeared to prevail in FG1, all the participants in the FG agreed that the existence of biomedical care had strengthened the health care system of the area, which was acknowledged by the older Xhosa women from FG1, as the following statement shows:

*The day the hospital came is the day when everybody became well.*

Another respondent lamented:

*I think all my children would be alive if the hospital was here when I gave birth to them.*

The two comments above clearly show how the older Xhosa women valued the existence of the hospital in their communities.

It was surprising that the group preferred to take all their illnesses to the hospital, including even those which could be classified as minor illnesses, despite them claiming that the hospital brought illnesses to the 18 villages of Gusi. The situation clearly requires careful consideration, as it might be linked to the fact that, where biomedicine exists in the villages, it still only addresses the proximate cause, being the disease that is apparent, but leaves the ultimate cause (i.e. the actual cause of illness and its social determinants, which, according to the indigenous approach of interpreting health and illness, is usually linked to broken relationships) unaddressed. (7,8,43,44) Very little communication occurs between the health care providers and the patients, with the consequence of the patient leaving the hospital or clinic without understanding the disease, the cause and the method of treatment concerned.

#### **5.4.2 Focus Group 2: Management of the health problems within the home situation**

FG2 appeared to address issues differently to the way in which the above group did. In said group, women were unable to specify whether their husbands were alive or dead, although they were asked about their condition by the researcher. The researcher perceived that their responses were due to the fact that, in village life, as the older Xhosa women had already confirmed:

*You are taught at home; we are marrying you to that household.*

A villager married the whole family, so if a husband left or died, there were still people to whom they were married and who looked after one (in some instances, the protection extended to one having to marry the brother of one's dead or departed husband), meaning the family of the household. (43,44) The approach concerned had been quite useful for women who were left as widows, or for some whose husbands had never returned from the mines, due to them possibly having found a new partner. (44) Such women are supported by the family that is left behind. They could not claim whether their husbands were alive or dead in front of the men of the village, as, if they did so, it would be perceived as a complaint that their family was not supporting them. The support provided to such women helps to ensure that the harmony and welfare of the widow's home health status is supported by those that are still alive. Even if the husband has left and never returns to the village, the relatives are expected to look after the wife who is left on her own. Her state of health and well-being is seen as not only impacting on her household, but also on the village as a whole.

The village is seen as one unit, and the problems that undermine the health status of one home result in an unhealthy village. It appeared that the village(s) still addressed health-related issues as a collective problem. (7,8,43,60)

FG2 started by acknowledging that the first help came from the home. It was difficult for them to explain what the first help was, but it appeared to amount to taking them back when the home was the only available health care provider. It appeared that they did not take their health seriously, but that they rather traded their health knowledge for their awareness of God. It is important to note that different concepts of health, education and religion were introduced by Dutch ministers of religion to the Amabomvane people. (30) It appears that the group was lamenting the fact that they had neglected health issues, instead of which they had allowed ministers of religion to take over both their spiritual and health needs, as they did not develop their IHK within the home, which many scholars classified as traditional knowledge. (7,8) Health experts from the domain were classified as traditional healers, although the indigenous peoples of the world challenged the notion, explaining that indigenous knowledge was always developing and changing. (7,8) Instead, they allowed the Dutch ministers of religion to run their health needs and to develop the hospital. It was already highlighted in the literature review that the promotion of IHK was hindered by religious groups and colonisation, as the need to conform to educational expectations and modern civilisation norms became unavoidable. (7,8,30) It appears that the participants of FG2 struggled to balance the new incoming knowledge of the coloniser with their own interests in managing their health in the home. This resulted in a combination of responses that, on one side, were about lamenting what they had done in allowing their health to be managed and processed by outsiders. They felt that they had traded their health for Christianity, in terms of which, according to the Bomvane person, health and religion were combined. By first ignoring that they already had a God to whom they related through ancestral reverence, they had angered the ancestors (30,43,44), resulting in their ill health. Their neglect in allowing their health to be managed by other people, and not by the home, where ancestral reverence was meant to be uppermost, had deepened their plight, thus causing more ill health to the home. Hence, then, in the prevailing situation, the best approach was to return home, where ill health started, and where wellness could be reclaimed through the appeasement of ancestors and through the cultivation of the knowledge of the management of health problems that was held by the older Xhosa women. (30,43,44,95-98)

Even the so-called 'traditional healers' would not have completed the healing of the person if she/he had not strengthened and assisted the home to reconcile with the ancestors and to

call them to re-establish their duty of protecting the home and its inhabitants. (30,95-98) Illness was seen and interpreted as a period during which the ancestors were neglecting their duties of looking after the home and of keeping it safe from disease and enemies. The only time that they behaved in this manner was when they were angry, due to the behaviour of some of those living in the home. Hence, their anger pointed to a need to appease and reconcile them by means of conducting a ritual. (30,93-98) In the ritual, a respected member of the family, an elite older Xhosa woman, or a traditional healer would acknowledge the areas that had undermined the health integrity of the home, including the role played by specific individuals who were responsible for doing so. Their forgiveness would be asked, and the promise would be made to them to abide by the rules and regulations of the family and culture, which would ultimately restore the health of the home. (43,44)

The types of diseases that the group saw as blighting the community were alcoholism, drug abuse and HIV/AIDS. It appears that, in FG2, they only started with complex conditions that could be seen as epidemics in the 18 villages of Gusi (TB, HIV/AIDS, alcoholism and drug abuse). This was unlike the older Xhosa women from FG3, who appeared to still be using the approach of breaking down illness into smaller components (unruly children, broken relationships, and lack of production of food) from the ultimate cause, until the disease was reached, perhaps at epidemic level. (43,44) FG2 lacked both prevention and treatment strategies, but instead took all those who were ill to the hospital. In terms of description of health and illness, FG2 could identify neither the determinants of social health nor of illness, leading the researcher to believe that, since the group had these limitations, it would be difficult for them to devise strategies of how to heal the illnesses. The researcher perceived that, for the diseases that they mentioned, basic things could be done at home to prevent the spread of HIV/AIDS, alcoholism and drug abuse. (111,112) The same group 'borrowed' a patient from the hospital, saying that they were bringing the relative home to meet a visiting relative. The doctors allowed this, as they saw it as part of healing, as it was assumed that the patient would be happy to see the relative. But instead, the patient was taken home to visit a traditional healer, leaving their level of dissatisfaction with the hospital care that they had received unaddressed. Again, with regards to what appeared to be the reluctance of the patient to comply with the healing process, the researcher perceived that the group might have lost insight into how long the body took to heal, as they appeared to have lost touch with their observational skills, since even those with minor illnesses were taken to the hospital. (3,17-19)

The lack of work (projects), the absence of toilets and the need to drink water from the rivers that were also used by animals was seen as problematic, with how such conditions caused

illnesses being left unexplained. They seemed to want to wait for the government to deal with their problems, even though they had already explained that it was slow on delivery, as the statement below explains:

*There are no projects. People are not sure when projects start. People are not motivated, and those that lead disappear. We are also waiting for the government.*

The session closed with an FG member lamenting:

*There is poor health; we are dying. We need an ambulance.*

Katzellenbogen (82) speaks about 'the dangerous cliff' that many of the public health programmes ignore; she uses the analogy of dealing with the problem by placing an ambulance below the cliff to catch the injured that roll down it. (82) She strongly advocates for disease prevention and health promotion programmes that will turn the tide and curtail the revolving door syndrome of patients to primary health services. It has already been shown by older Xhosa women from FG3, in their discussion of their definition of health, that to be proactive in health strategies requires addressing the social determinants of health. It appears that the participants in the group would rather be passive receivers of health care and wait for other people to come and give them jobs, to build them toilets, and to prevent their animals from drinking with them, while complaining about the management of health issues that they received from the hospital. (132-135) As in Katzellenbogen's (82) analogy of the 'dangerous cliff', they were waiting for the ambulance below 'the dangerous cliff' to pick their relatives up, while they continued to lament and wait.

Such public health researchers as Katzellenbogen (82), Kickbusch (132), Hills (133), Hancock (134), and Catford (135) have suggested the need to focus on health promotion and disease prevention as a way of dealing with the problem in health. This appears not to be far off from what the IHK treatments suggested in regard to not only addressing the locus of the disease, but also in regard to addressing the origin of the disease (whether a broken relationship, angry ancestors, disrespectful children, the lack of ploughing for food, and the buying of food) first, thereby restoring a state of systematic balance of the individual and his/her inner and outer environment. (7,8,43,44) The state of awareness (being aware with regard to where and how illness originated, or how the prevailing situation would ultimately lead to illness) was considered the basis of all material existence - according to the indigenous peoples, it was the state of pure awareness alone that appeared to assist an individual to become aware of their health status, as well as of both the negative and positive influence of the status (7,8,43,44), including the appropriate response to take. The state of awareness might turn the tide against such diseases as HIV/AIDS and alcohol and drug abuse, as well as against the lack of projects and toilets - perhaps their idea of the first

knowledge being found in the home is not a bad one, as they can possibly start their own projects and build their own toilets, as the older Xhosa women from FG2 suggested in regards to what brought health to their villages.

#### **5.4.3 Focus Group 3: Management of the health problems within the home situation**

FG3 appeared to be aware that they were the Amabomvane people, with which knowledge they were content. (30) They were proud of the herbs that their environment offered them, maintaining that their environments were where 'green things' were obtained. The descriptor 'green', within the Xhosa tradition, means that health and life thrive, as, when things are green in the area, it is usually the rainy season, during which people can plough food to feed their families, and so thrive. It is also a time of thanking the ancestors through the conducting of celebrations and rituals glorifying the rain and the production of food. (30,93-98) They were willing to share their knowledge and understanding with the researcher, whom they saw as a stranger in their villages. As was highlighted by a participant:

*Here within the Mbomvane tribe - this is where you get medication.*

*This is where you can get ityholo and impepho - this is where you can get green things.*

Another participant expanded on the above in the following way:

*This is about being women, explaining to the visitor.*

As home healers, they needed to consider the immunity of the person as, according to them, people's immunity was at a low level, which might be related to the prevalence of HIV/AIDS. The elite older women expressed a belief that the herbs that they had previously used, especially those with a laxative effect, had to be stopped, and, instead, they strongly advised that, in this type of situation, the person should be taken to hospital. It appeared that the older Xhosa women had already discovered some of the dangerous components of their healing practices, and that they were responding to this by not managing the person themselves, but by referring them to the hospital. (3,19)

They were aware of the different conditions and had a way of diagnosing them. Their diagnostic skills depended more on observational skills, with functionality being the key indicator of the state of illness/health, as the following statement explains:

*When a child is sick, a child will not play. If you throw the child up, the child cries. It can start early with you, as a parent, feeling that your breasts are tingling. The child will not play and cries; maybe the child is teething.*

The above is also related to the strong link that the woman is expected to have with her child, and that, as a woman, your body parts should start giving you a sign when your child is not doing well. The belief is related to the indigenous health belief system concerning the interconnectedness of things and life. (7,8) For example, through dreams and body feelings, they could determine when both a good and a bad thing was about to befall them and their families. They also used what would be classified as differential diagnosis in biomedicine in assessing the improvement of their patients, as the statement below explains:

*In general, a person takes a week or slightly more when you, as the older Xhosa woman, are managing the health problem. What is important is to see a person getting better. The one with diarrhoea with blood stains, the diarrhoea must get better and the blood stains must stop, and the one coughing out blood, this must stop, and the sputum should be clear.*

For an adult, waking up in the morning, dressing and starting with your chores is a sign that you are well. They used functionality as a yardstick for measuring health and illness. The family must wake up and perform the duties of the home, according to the chronological age of each person in the home, with babies playing, men going to plough the fields, younger women doing the chores at home, and the older Xhosa women sitting back and managing all the functions, as they all were seen as contributing to the health of the home. (3,60) To them, the above was a sign of wellness. Their approach to illness was to relieve the symptoms that they had observed. Doing so could be problematic sometimes in regard to the taking of medicines for mental illness and seizures that caused tiredness and that encouraged one to sleep, as this was seen as not being a good sign. Usually, at said juncture, an older Xhosa woman took the patient to a traditional healer, as they had concluded that the hospital medication was not working.

They used mainly herbs and processes that they perceived would alleviate the symptoms. They differentiated between the presentations of symptoms in the following way:

*Coughing non-stop, TB, is a special one. You do not stop, and you start coughing out bloody sputum or ultimately blood.*

With regard to the critical incidents regarding each of the conditions that they mentioned, they had a way of picking up on when the condition was reaching the critical level, which was related to the combined worsening of symptoms, and to a severe decrease in the level of functionality, and in the ability to relate to the family. The person would be seen as breaking the interconnectedness of the family unit by isolating him/herself (which was seen as not being a good sign, as the older Xhosa women described this as the way, in terms of which a person expressed wanting to die quietly without the relatives disturbing him, and they

brought him back from dying by reminding him of his role and responsibility as a family member) (7), or of him/her wanting to be too close to a particular person. For example, a baby clinging to his/her mother, or to a particular person whom they liked, when they were ill, was seen as not being a good sign. (7,8) A child who was well should be playing and reaching out to explore relationships with all family members and even strangers.

It appears that, for some of the conditions, by the time that they were at a specific level of progression, the older Xhosa women should have already referred the person to the hospital, once they had picked up on the first early symptoms. It is also important to mention that there were many reasons, such as the distances to travel, the need for transport, and the amount of time during which a relative's condition worsened (which sometimes occurred at night, or when there was no money to take the relative to the health care facility), that made relatives delay referring a ill relative to a health centre. (3,19)

Early referral and prompt intervention is encouraged in an effective public care system. (82) It appeared to the researcher that they waited for too long before they referred the person to the hospital. There was a question as to whether it was the best referral source for them. It appeared that the women from FG3 referred people more to the hospital than to other elite Xhosa women or to the traditional healers. It was also unclear regarding how many of those whom they referred to the hospital were discharged from the hospital fully recovered, as it has already been explained that it appeared that they took their relatives to the hospital when the signs and symptoms of illness were advanced. There were conditions that the older Xhosa women from FG3 did not see a need to refer to the hospital (see Table 4.10, p. 140). Some of the ailments appear to be similar to the minor health ailments that have been mentioned by other researchers, as were discussed in Chapter 2. (3,19,68,69) The older Xhosa women appeared to be able to determine that they could fully manage the ailments at home, but the researcher still cautions that they require a cut-off point, even for the ailments that appear minor, as it has already been explained in Chapter 2 that what appears to be minor can complicate into a major ailment. (3,19)

Though the women from FG3 saw the worsening of the conditions as critical incidents, the findings have also brought two critical incidents to the fore from the FG, namely childbirth and polygamous relationships. The first critical incident, that the women, as with some of the illnesses mentioned above, did not refer to the hospital, as they saw themselves as being in total control of women giving birth. They seemed to manage the pregnancy of younger women from prenatal to postnatal care. Some of the skills that appeared to come to them naturally, without them having learnt them from anywhere, they saw as being talent given by God. (30)

The problem started when the woman then moved from her home to go and raise the child in her maternal home, with the aim of preventing early conception and of giving the new mother a break from all the demands of her own household, including those of her husband. This gave the husband an opportunity to acquire a second wife, as it appeared that he could not sustain himself without the presence of a wife. (43) The manner in which this was all done showed how the men still had the upper hand and were the ones in control in the Amabomvane culture (30), whereby it appeared that the wife was expected to accept that her husband had taken a second or third wife while she was away looking after their child and recuperating from childbirth.

It appears that the role that the older Xhosa women had cut out for themselves, of taking care of the health of the home and all its demands, could be a double burden that backfired on them and that undermined the very health determinants that they specified and held dear. This gave the older Xhosa women an extra burden of having to manage the extra tensions that were caused by how some of the polygamous relationships were entered into. This further weakened the role that the older Xhosa women could play as managers of health problems within the home situation, as their own health was also compromised. Maleana (43) warns the public health specialist against coming down too strongly on polygamous relationships in Africa, until such time as there is an effective PHC system, as such relationships can assist in preventing the spread of STDs and HIV/AIDS, as well as serving as a form of contraception.

A caution should be given to Maleana that it is not as simple as the above in modern times, with the husband being away working as a migrant labourer in mines most of the time. During said time, he might enter into other extramarital relationships that result in him being infected and affected with HIV/AIDS. When he returns home infected by HIV/AIDS to his circle of wives, he still demands his marital rights from them, thereby infecting them. Also, after his departure, the wives also enter into extramarital relationships, due to their loneliness, and when they are also affected with HIV/AIDS by their husbands, they are likely to affect other male villagers. Again, the words of the chieftain, with regard to the old concepts and the changes that had been brought in modern times into their environment, are brought to mind. (14) It appears that the cultural practice of one-sided polygamous marriages might require revisiting and checking for its relevancy in the present time.

#### **5.4.4 Focus Group 4: Management of the health problems within the home situation**

FG4's approach appeared not to be far off that of FG3, except that the former appeared to refer people less to the hospital. In terms of the illnesses that they managed and their referral pathways, they also referred the ill to an indigenous healer, even when the illnesses

concerned were far more complex (such as seizures and TB). Even if they had to go to hospital, they first prepared their own indigenous herbs, in case they were not happy with the management of the illness by the hospital personnel. In relation to certain illnesses (such as seizures), they concluded that the hospital personnel could not help them, and that only an indigenous healer could help, with them fluctuating in the case of others (such as TB) between the use of an indigenous healer and the hospital. This was in contrast to FG1 and FG3, who were sure that TB and seizures were managed holistically at the hospital.

In a study of the Bolivian and Amazonian peoples, Vandebroek (121) measured how distances from health facilities influenced the use of IHK. Their study showed that increased distance from the health facility was directly proportional to the increased usage of IHK and plants. The sampling strategy used in the current study was similar to that of Vandebroek. (121) As with Vandebroek, it is concluded in the present study that distances from the health care facility affected the responses of the older Xhosa women. Especially when they were faced with critical incidents, they chose the available expert, which, in their case, was the traditional healer, who might be closer to the home and also known to the family. Maleana and Lidell (43,44) have already specified the role of traditional healers among the indigenous people of Southern Africa, and have shown how they fill in the gap in the lack of a more comprehensive biomedical care system that is scattered and which, in some areas, is unavailable. (18,28,32)

FG4 too, like FG3, performed differential diagnosis, and placed illness within a hierarchy from mild to severe by grading the symptoms. There was a general perception in the group that one should not combine hospital and traditional medicine, and that, for some conditions, such as epilepsy, hospital medication did not help, as, once one took the medication, one became tired and became drowsy. They rather opted to take a person with epilepsy to a traditional healer. The older Xhosa women used functionality as a yardstick for wellness, and if the medication made the patient drowsy and wanting to retire to bed, they regarded it as a sign that one was not improving. (46) It appeared that there was a need for giving information and for teaching about the effects of medication, as well as about its side-effects, which could be tied to the continuous monitoring of the effects of drugs, especially in the case of such chronic illnesses as seizures.

The above monitoring could be managed by community health workers visiting the homes of those with chronic illnesses and giving feedback to the CNPs in the clinics with regard to the status of the person taking chronic medication. The FG participants blamed the present time with regard to such conditions as HIV/AIDS and the manner in which it is spread. To them, the previous method of abstaining from sex was the best approach. They did not blame their

male partner, as they felt that both partners were responsible for preventing direct coitus and its consequences. Their perception seemed to differ from the general perception that had previously been shared that a young bride must be a virgin, implying that the woman must guard her virginity. In the previous instance, no mention was made as to whether the young men must also be virgins when they marry. In relation to the intention of the young man to impregnate the young woman to demonstrate that she was 'used goods'. FG4 saw the responsibility of abstaining from being impregnated as being that of both the girls and the boys. The new way of thinking might need to be discussed in the village health forums and in the *imbizo* (i.e. the chief's meetings) in the village.

FG4 spoke of the need for early diagnosis in the case of cancer and for quick intervention, and how the hospital had been failing them in this regard. It has already been explained that the older Xhosa women also took a relative to the hospital quite late in the day, after symptoms and complications had set in. Also, because of their strong trust in indigenous healers, the impression was that they wasted time in vacillating between indigenous healers and the hospital, while the condition was growing more complicated. It was neither clear whether they explained the situation clearly and accurately enough to make the doctors in the hospital understand what was wrong with the patient, nor whether the translators, who were usually nurses, translated what the patients said well enough for the doctors to understand the patient's symptoms. There is a need for the assessment of the translation service at the hospital, and to see whether the nursing staff cannot be exempted from this responsibility, as they appear to be inadequate translators.

The older women were aware of there being no cure for malignant cancer. They were concerned about seizures never totally abating, even with medication. For the older women, for every indigenous illness there was a herb that was available for directly addressing the illness, since, with the hospital medication, they believed that the seizures would never go away. They opted to take the person struggling with seizures and epilepsy to the indigenous healer for treatment with an indigenous herb, which they believed helped to ease the complaint.

It is also important to note that FG4, unlike FG3, knew of no illness that they were absolutely sure that they could manage on their own before complications set in. This could be related to the fact that it appeared that the group was negatively affected by being chastised by health professionals when they had used their IHK at home on an ill relative. Hence, it seems that they were reactionary and did not wait for the condition to show whether their approach had worked or not. This was in contrast to the older Xhosa women in FG3, who appeared to be quite confident of their management skills, and who were also sure of when to relinquish

their treatment, and to whom they should refer the condition. There were nine illnesses that were found to be common in both FG3 and FG4 (see Table 4.12, p.149). The nine illnesses could be used as a starting point for developing a template for dealing with the health problems that were found to be endemic in the 18 villages of Gusi. Once the template has been completed, both those at home and at the hospital need to be encouraged, firstly, to understand the responsibility that each should take for the illness, and, secondly, each should have the skills and the resources to fulfil the role that has been assigned to them. The FG participants were aware of the signs of critical incidents, and saw death as forming part of a critical incident.

Neither FG3 nor FG4 mentioned bone fractures and mental illness, which the researcher saw as a study limitation. Eshete (89) worked in Tanzania with male traditional bonesetters. It appeared that fractures were seen by the older Xhosa women as being health problems that were not manageable within the home situation. In Eshete's situation (89), bonesetting was seen as a speciality that was conducted by an experienced bonesetter. Future studies should explore first aid possibilities within the home for bone fractures.

The issue of mental illness is a complex one in Xhosa households, as, sometimes, what is seen as schizophrenia, in terms of a biomedical explanation, is interpreted as a gift, as they see and describe things that other villagers can neither see nor describe. Niehaus (85) describes the challenges experienced in making a proper diagnosis in the case of patients with schizophrenia as a culture-bound syndrome (*Amafufunyana*) and a culture-specific event (*Ukuthwasa*). He concludes that the diagnosis and the implications for the treatment or the prognosis of schizophrenia still require clarification amongst the Xhosa. (85) The current study perceives that the situation has been exacerbated by the implementation of disability grants for people with mental illness and for other people with impairment and disability, whereby, in an area that is blighted by poverty, bringing in a disability grant because of one's impairment might be more advantageous for a family than would be receiving a clear diagnosis and proper management for a mental condition. 161 Many of the families in the area surveyed depended on social grants for their financial support. Barron and Roma-Readon (162) explain that the rural areas in South Africa are the poorest, most underserved and historically most neglected areas in the country. In 2001, seven of the ten poorest municipalities in South Africa were located in the rural Eastern Cape areas. (163) Jelsma et al (164) explain that, in 2008 in the Eastern Cape, about 74% of those with disabilities received disability grants while Surender and Ntshongwane (165) and Lund (166) expand on the challenges of distributing disability grants in a fair and equitable manner.

FG4 appeared to lack trust in the support that they were given by the hospital. They explained, in relation to a critical incident, that they first prepared their own medication before going to the hospital, in case they did not like and feel confident about the management strategy given to them by the hospital. In retrospect, this shows that the older Xhosa women had some knowledge of how to manage their illnesses in their home situation; hence, they were able to compare their own health knowledge with the hospital management of the health problem in their family. (3) The danger of drawing such a comparison was related to the fact that there was minimal explanation given about the hospital management, hence it became difficult for the older Xhosa women to understand how the hospital management would work with their relatives, or to do away with outdated approaches. The case study of the older Xhosa woman who dreamed of her maternal mother directing her to the herb that would assist a relative suggests that such knowledge, which the older Xhosa woman had in her unconscious, was given to her by her mother-in-law. Now that she herself was a mother-in-law, and was required to solve a similar problem in her own grandchild, the knowledge that had previously been suppressed in her unconscious surfaced once more in the dream. (40,98)

Though all four FGs were unhappy that they were chastised by the health professionals at the hospital for having tried something at home to curb the illness of their relatives, FG4 was the only group that appeared to be angry with regard to their knowledge being ignored, and with regard to them being chastised for using it by the health care providers in the area. Such a response could be related to the issues of access to health services, as they were the farthest from the hospital, and they felt that their home-based attempts were neither recognised nor appreciated. (40,121) When the researcher asked what should be done to remedy the situation, they appeared to despair, appearing to ignore the minor health ailments, unlike FG3, only treating them when they had worsened, in which case they would refer them to an outsider, such as a traditional healer. It appeared to the researcher that their fear of being chastised and their underlying anger, as well as their sense of despair, was preventing them from thinking critically and systematically about what the researcher differentiated into minor and major health problems. They felt that they were being treated like children, hence their rebellion. They seemed to be shifting the responsibility for, and the assertion of, their knowledge being taken seriously by health professionals to their children. (73,146)

The majority of the women in said FG were unschooled, although they had sent their children to school, and some of them were already health professionals (nurses at any level up to that of matron). (30) The current researcher perceived that the shifting that took place in dealing

with health professionals when they were chastised by them with regard to them managing their health problems using IHK might be related to the fact that their educated children could face the health professionals on more of an equal footing than they could. In contrast, in the transitional conversations conducted in the current study, one of the nurse practitioners, who was born in Gusi, was shocked and surprised at the health-seeking behaviour of the villagers. To her, it felt as though they had relinquished their knowledge regarding managing minor health problems to the clinics, which she found unacceptable, as it meant that the clinics had a far greater workload than they would otherwise have had. This could lead to the health professionals concerned missing out on a proper diagnosis and on the support that was required of them for those with serious illnesses. (17,18,19,168) Unlike in Khayelitsha, where health professionals and older Xhosa women united in their desire for IHK to be revived and for an exploration of the rural Eastern Province for authentic home remedies (which might have been viewed as retrogressive) (3,11,13,14), it appears that, in the rural area of Bomvaneland under study, that there was a general blaming of one another, without anyone taking responsibility for the prevailing situation. Where and by whom health problems in general and minor health problems in particular should be managed was contested. Researchers into IKSs, such as Serpell (146), Mkhize (73) and Werner and Saunders (81), warn of educational programmes that create local elites whose views and lifestyles resemble those of their middle-class Western mentors, and which differ from those of their own local societies. (81) Whittaker (109) challenges educators regarding their response to entering into a social contract in health education, and suggests that there might be a need to adopt responses that have not previously been thought of. For example, the three-tier educational plan for medical doctors that was implemented by Sinnott and Wittmann (37) for training doctors focuses on cultural awareness around health issues in order to facilitate positive experiences with indigenous patients. The two researchers (37) concluded their research by saying that an important step towards improving the health of indigenous people was the introduction of a culturally appropriate health sciences education programme. (37)

Discussion of the problem of who should manage health problems and how they should be managed within the home continued for FG4, with the older Xhosa women managing situations that were far beyond their realm of expertise, especially in the light of them lacking a full understanding of the aetiology and pathophysiology of the illnesses concerned, as the critical incident of the woman with vaginal-intestinal connection shows. The older Xhosa women, too, had an aspect, such as child delivery, about which they seemed to be completely confident, and which they could use as a defence against the onslaught that they felt from the health professionals regarding the first help that they applied to their relatives when they were ill at home. What has been mentioned by previous researchers into science

and indigenous knowledge as regards each upping the game against the other (43,72,77,78) appeared to be happening, at the time of the current study, within the 18 villages of Gusi. The one upmanship being played out in the villages involved the older Xhosa women dismissing the biomedical approach to certain illnesses and the health professionals chastising them for daring to think that they could manage health problems within the home, with them, simultaneously, also being frustrated by the fact that the women tended to bring all illnesses to them, even those that they regarded as minor, which could have been managed at home. The situation left the older Xhosa women confused regarding the exact role that they should play within the home when their relatives were ill. The South African health plan that is aimed at resourcing health services in the country, together with revitalising PHC, needs to take cognisance of the role played by older Xhosa women in managing health problems within their own homes, while health services are being improved in the young democracy. (15,160,167) Clarification of which health problems should be managed by the older Xhosa women within their own homes should be given, and clear guidelines should be drawn up, in collaboration with the older Xhosa women, regarding cut-off points for when they should stop home management and to whom they should then refer the patient.

## **5.5 THE CHALLENGES EXPERIENCED BY THE OLDER XHOSA WOMEN AND THEIR RELATIVES WHEN ATTEMPTING TO ACCESS HEALTH CARE SERVICES**

The main aim of the current study was not to explore the PHC services that were offered to the Gusi villagers. Discussing and mentioning such care is related to the three challenges that emerged from the data collected from the older Xhosa women once their management strategies were found not to be working and they had to access health care at the local clinics, or at the hospital. As PHC facilities for the villagers, there were the hospital and the eight clinics, of which the majority had just recently opened. Private general practitioners (GPs) could be found in the nearest towns (Elliotdale and Mqanduli), and sometimes relatives travelled as far as Umtata and East London to see a popular GP). The challenges about which the older people complained in relation to them attempting to access the public health services were mainly expressed regarding the hospital. The older Xhosa women mentioned mainly three challenges that they encountered when they were attempting to access the health care service, especially after utilising their IHK at home, and the relative concerned not having improved in health under such care. The challenges, which are discussed below, were:

- distance from the health services;
- communication problems; and

- lack of trust.

### 5.5.1 Distance from the health services

In the 18 villages of Gusi, it appears that distance had a direct impact on the health-seeking behaviour of clients who sought help from the PHC services. The findings from the four FGs are similar to those made in relation to the indigenous communities in Bolivia and the Amazon. The FGs and the communities that were close to the health facility wanted all health problems to be managed by the health facility, whereas those who were farther away from the health facility tried to manage the health problem within the home, using whatever means they had available, including IHK. (121) They also appeared to be managing health problems that were quite complex, and reporting them quite late, when complications had already set in.

The above points to the need for easily available transport to be available for taking a ill person to the health care service, or for the implementation of mobile health care services. Those who were close to the health care facility appeared to bring all their health problems to the health care facility, even those that could be classified as minor. (3,18,19) There is a need for developing a plan and strategy to manage health problems within the home, using IHK and an identification system, for which ailments should be managed by the health facility, and when one should present with the ailment at the health facility. The proposed revitalisation of PHC (160) and of the National Health Insurance (167) will have to take all such matters into consideration during the overhaul of PHC in rural areas.

It is also important to explain that the hospital was almost in the centre of the 18 villages of Gusi, the two rivers and their tributaries, and the sea (the Xhora and Mbhashe rivers - see figures 1.1 and 3.1). Accessing the hospital in a rainy season (i.e. summer) was a problem for some of the villages, as sometimes the two rivers filled to capacity. In contrast, the elite older Xhosa women, in the in-depth interviews, saw summers as good, as they explained that the wet season brought moisture to areas that were rich in herbs, as well as to the forest. Unfortunately, the herbal resources were far from FG1 and FG2. The hospital was built on a rocky area, hence its name: Madwaleni Hospital (*idwala* in Xhosa means 'a sheet of rock'). It has already been explained that the older Xhosa women from FG1 and FG2 maintained that they did not use herbs and IHK for managing health problems within the home. This further supported the argument made by the older Xhosa women from Khayelitsha that the lack of the availability of herbs might also have a direct impact on health-seeking behaviour. (3,19,121) The areas that the elite older Xhosa women said were rich in herbs require investigation. Once the herbs have been tested for their medicinal effect, they should be made readily available to older Xhosa women who stay at some distance from the

areas. It is believed that the older Xhosa women have not forgotten about the nature and the use of the herbs. Three of the elite older Xhosa women from FG1 and FG2 still sent their grandchildren to walk in the damp areas to collect herbs.

### **5.5.2 Communication problems between the older Xhosa women, their relatives and the health care providers at the hospital**

The current study has identified three areas where a communication breakdown between the patients and their relatives, on the one side, and the health professionals at the hospital, on the other, had occurred. The issue threatened to undermine the successful management of health problems in the 18 villages of Gusi, by not providing the IHK practitioners with a platform for discussion, interrogation and consideration of the good attributes of IHK, which should be appreciated as part of the management strategies used by the Gusi villagers. As older Xhosa women were losing IHK at quite a fast rate, it appeared that the rate of learning about biomedicine was quite slow, as has already been shown in relation to the older Xhosa women from FG1 and FG2, which meant a double loss of health resources for the rural community. A discussion follows of the communication problems experienced between the older Xhosa women, their relatives and the health care providers at the hospital.

#### **5.5.2.1 *The older Xhosa women and the health professionals manning the health services in the Gusi villages***

The older Xhosa women complained that they could not be honest about the IHK that they had utilised before they brought their relatives to the health service, as they were chastised by health professionals as having worsened the condition of the patient. The health professionals, who were predominantly nurses, saw the Amabomvane people as difficult to change and educate about the management of health problems by the health service. They also believed that they worsened the ill health of their relatives, as they lacked a biomedical understanding, firstly, of the pathophysiology of disease and, secondly, of how disease is managed from a biomedical perspective. It also appeared that the health professionals were insensitive to the health access problems that their patients experienced when trying to access health services, especially at night. (18,19)

Such thinking by the health care providers of the area, that the older Xhosa women should not manage their ill relatives when they were ill at home, contradicts the findings of many researchers who see the implementation of PHC services as not being comprehensive, with some areas existing totally without coverage, and with certain areas having services, but not holistic ones. (10,11,12,18,19) In contrast, in the clinics, CNPs were concerned about the Gusi villagers presenting with what could be classified as minor illnesses on a daily basis. Such practitioners seemed to be totally unaware of how their attitudes towards the patients

and their relatives was preventing the relatives from sharing the remedies that they had tried at home. The result was a fear of the patients trying to use IHK at home again, so that, instead, they brought all health concerns to the health centre, even what the CNPs classified as minor health problems that could, in fact, be managed at home. The impasse requires resolution, which could possibly be achieved in the form of village health forums, such as those that they had in Khayelitsha, when they were faced with the problem of overcrowding of the CHCs. (3,19,20,21)

**5.5.2.2 *The attitudes of the nurses towards doctors who could not communicate in Xhosa, and towards the patients who required the doctors to hear and understand the history of their illness***

The hospital doctors used nurses as interpreters for their Xhosa-speaking patients. The practice was open to a number of misuses with regard to the doctor and the patient by the nurses who acted as interpreters for them. (TOC3) The Xhosa patient and the English-speaking doctor were vulnerable, as they could neither communicate with, nor understand, one another with regard to the patient's illness. Malcolm (70) explains the pitfalls of poor communication between patients and doctors in medical practice. His concern is further highlighted by DeVilliers (169) and Blitz (170), who also expand on the importance of communication in a conducive client-doctor relationship. Nurses who have been required to interpret do not see doing so as being their role. It is assumed that the doctors cannot have the same understanding of the aetiology of the illness as the patients explaining their case do, because the nurses summarise what is told by the patients about their illness, omitting points that they consider to be unimportant for the doctor. Some of the nurses end up avoiding the responsibility of translating for the doctor and the patients because they seem not to perceive this as their role. (TOC 3)

Proper interpreters should be trained, including in sign language interpretation, in order to enable them to interpret for deaf patients. As the majority of the nurses are from one or other of the 18 Gusi villages, they have some understanding of the prevailing culture of the area and of the IHK possessed by the older Xhosa women, because they were once the grandchildren of such grandmothers. One of the CNPs surveyed had shared the concern that the older Xhosa women were going to lose their knowledge of how to manage minor health problems within the home. What she overlooked was that their approach to the older Xhosa women, when they had tried a home remedy and the patient showed some complications, was the negative effects of them chastising them.

The current researcher further suggests that the nurses should develop a social contract, in terms of which they should use their understanding of indigenous health practices as a

bridge to enhance the doctors' understanding of the indigenous interpretation of the patient's illness, including what the patient might have used at home to manage his/her illness. Nurses must also be encouraged to give a proper explanation to the patient of the doctor's response and interpretation of the patient's illness, as well as of the management strategies that he/she is planning to use to manage the patient's illness. (109) Only when this happens can the doctors start acknowledging the importance of, and learning about, IHK. The patients could then also learn about biomedicine, and an exchange of skills and competencies could start from an informed position.

### **5.5.2.3 *The hospital doctors who cannot communicate with their patients in Xhosa***

The doctors at the hospital were mainly white doctors who could not speak Xhosa. (30) The issue of health and illness requires the doctor to understand the historical background of the patient's illness directly from the patient. (43,44) It is believed that much valuable information regarding the patient's illness was being lost during interpretation sessions. (19,54,70) The current study is motivating for all the doctors who cannot speak Xhosa and who are not from the 18 villages of Gusi to be required to learn Xhosa before they start to work at the hospital that is situated in the area. Such training should include the coverage of cultural concepts, including how to be a Bomvane, as it has already been shown by the current study that a Bomvane person, like the Maori people of New Zealand, feels healthy when she/he is aligned with her/his cultural practices. (30,46)

### **5.5.3 Lack of trust**

The current study has exposed the lack of trust that existed between both the older Xhosa women and the health professionals in the area. The former applied indigenous medication to their relatives without informing the hospital, telling their relatives to hide the fact that they had taken the medication. They also secretly took patients to a traditional healer and sometimes (FG3, critical incident 3, p. 151) prepared indigenous medication before going to the hospital, in case they lacked confidence in the manner of treatment, and the medication prescribed, by the doctors (FG4, critical incident 2, pg. 150). There was no guarantee that the patient would not land up in the hands of a charlatan, as traditional healers, too, continued to practise their healing vocation, unrecognised by the hospital, which some saw as an avenue for pretending to be traditional healers, when, in reality, they were not. (TOC3,72) The granddaughter of an elite woman said that her grandmother was looking forward to the day that her knowledge would be acknowledged by the hospital. Also, when her healing strategies did not work, she did not refer the patient to another traditional healer, but rather to the hospital. The granddaughter saw her grandmother as being confident of her strategy and knowledge regarding what worked and what did not work. What she was

unhappy about was how the hospital staff looked down upon her attempts to manage the health problem within the home. The health professionals classified the people of Gusi as *Amabomvane*. (30) The term referred to those who were set in their ways. They trusted their IHK, and would continue using it, even if the patient was growing more ill, and would only bring a person to the hospital when they were just about to die. The health professionals did not see such stubbornness, self-determination and strong sense of self-worth as an asset that could be utilised positively in health promotion programmes. (82,132-135)

It appeared that, in the 18 villages, the promoters of biomedicine and IHK were acting against each other, with each side claiming supremacy. The older Xhosa women in FG1 and FG2 had opted to keep quiet and to practise their IHK silently, even if doing so was via charlatans. The situation was unhealthy for both the IHK utilised by the older Xhosa women and for the biomedical practice, as well as for the ill patients and for the inhabitants of Gusi as a whole. The starting point should be the revitalisation of PHC, using the patient-centred approach of family medicine. To listen to the patient and to understand the patient's context, according to the family medicine practitioners, was the first step to re-establishing the health of the patient. (158,165)

## **5.6 PERCEPTIONS FROM THE OLDER XHOSA WOMEN WITH REGARD TO WHY THEY WERE CONSULTED BY THEIR FAMILIES WHEN A FAMILY MEMBER WAS ILL**

In the current study, the older Xhosa women, the family members of older Xhosa women, and the elite older Xhosa women all confirmed that the best person to look after health issues in the home was the older Xhosa woman. (3,19,30) Such thinking is supported by Achtenberg (39) and Clough (40), who both claim that women have always been healers and carers, while Boneham and Sixsmith (38) admire the skills that women develop as they grow older, and which they use on their families and the surrounding communities, in assisting them to cope with daily life challenges. Such support is what the older women perceived to be lacking in Khayelitsha, in terms of which they stated that, because of migration to the urban areas and the breaking down of family units, with the grandmothers being left in the Eastern Cape, there were no grandmothers to support the middle generation with managing minor health ailments at home (hence the overcrowding in CHCs). (3,19) Those who were present (in Khayelitsha, Cape Town) were not given the space in which to practise their IHK by their families, as they lacked the status that the older Xhosa women from the 18 Gusi villages still enjoyed in their homes and villages. (3,60)

It appeared that the caring attribute also assisted the older Xhosa women to gather IHK strategies, as well as in their decision-making with regard to which activity to focus on first. (8) From the description given by the other family members of the older Xhosa women, there were many balls that they had to juggle and to keep aloft in order to sustain the health of the home. (138) The older Xhosa women mainly preferred disease prevention and health promotion in terms of maintaining the health of the home, as well as that of the village, rather than in terms of intervening when a health problem had already erupted. Therefore, they busied themselves with a myriad of activities, including monitoring the health status of the home and their family, to ensure that the health of the home was guaranteed. (37-40,82)

One of the daughters-in-law of an elite older Xhosa woman described the latter's movements when she had to manage a health problem, in the following words:

*What makes her be a mother is that she moves fast, and what makes her move fast is that she has patience. I start with my mother-in-law when my child is sick. She is the mother whom we trust and who jumps first. The person who is the father is hard. A mother is like this, because she is the birth giver. I, too, am patient and, once I am old, I see myself having the same qualities as my mother-in-law (does).*

The daughter-in-law, in the above excerpt, appears sometimes to be contradicting herself, as one would tend to think that moving fast cannot be combined with patience. It appears that this is linked to an instinct that is embedded in mothers, in terms of which she moves fast to pick up a falling child when the child turns and grabs at something hot, but is patient enough to move fast to prevent the child from burning him/herself. It seems that the older Xhosa women were in touch with their instinct of caring and preventing harm from happening in the family, as well as with their ability to help relieve pain and suffering, utilising whatever measures were available to them. (30,60) One of the cornerstones of the ethics of health care is preventing suffering and doing no harm. (168) From the current study, it emerges that this is the caring skill that the older Xhosa women were taught at an early stage of their development.

In the present study, it appears that perceptions about caring and healing, as well as about the prevention of harm and suffering that the older Xhosa women had was what they expected from the health professionals' side in their health services. (116,168) For health professionals, the study proposes that the skill could be taught during the early stages of their training. An inventory could be conducted during the health science curriculum review, for the graduate attributes of health professionals in training institutions to include some of the attributes and skills of the older Xhosa women, especially those that are linked to caring. It is important that, when the review takes place, the health professionals concerned should

understand the IHK that is utilised by the older Xhosa women in their own home, as, at present, the health professionals are not prepared to listen to when, how and what the older Xhosa women use to manage the health problems of their relatives. They do not believe that the health approaches of the older women from the 18 villages of Gusi prevent harm and that they relieve suffering.

In contrast, the older Xhosa women from Khayelitsha believe, when your relative is ill at night (3,19), that you should do whatever it takes to try and relieve suffering, which is where the older Xhosa women intervene. The lack of appreciation of what the patient and his/her relatives have used prior to visiting the health service contradicts the patient-centred approach and the communication skills that are promoted by DeVilliers in her chapter on consultation (169) and Blitz's (170) commendation of communication skills for family physicians, in terms of which they should see the patient and her/his relative as having an equal status to that of the health professional in managing health problems and in ensuring good health outcomes. (169,170)

The data in the current study appear to indicate that health professionals who sign up for training are uncaring, and are not taught to care during their training. This goes strongly against the general belief that health professionals who sign up for training are caring by nature. Also, the nursing profession is dominated by women, thus they share the female characteristic of caring with the older Xhosa women. The present study concludes that the situation that is happening in the 18 villages of Gusi is similar to that which was happening in the overcrowded CHCs in Khayelitsha, in terms of which the patients were also complaining of being given medication without any explanation about their condition and the effects of the medication. (18,19) As primary health facilities appear to be struggling with the burden of disease and with the revolving door syndrome of patients (18,19), which appears to be their daily experience of their working environment, it remains unclear with regard to who should support the health professionals regarding the possibility of burnout in their work. (138). Mashile has spoken about how the lack of caring and support can also undermine and erode the juggling skills of women that make them such effective carers. (138) The nurses, too, require support in their work, so that they can be effective carers.

The daughter-in-law saw her mother-in-law as somebody who jumped first. She did not say, because she has given birth, that she jumped first, but said that, as the birth giver, she jumped first. To the researcher, this conveys an understanding of why all the women in the village, including those who gave birth and those who did not, were seen by the villagers as the carers for all the village children. The researcher thinks that jumping first requires a combination of skills that are both learned and that are personal attributes. The caring

approach of the Amabomvane older Xhosa women appears not to be very different to the approach taken by women in other parts of the world. The aboriginal women of Australia dance with their hands cupped, showing that they assist with the growth of their children, foster love in the home and look after the health of the people and the land. (137) Clough (40) maintains that pregnancy, giving birth, raising children, caring and nurturing are all part of being a woman. Murdock (62) equates this to being like a guide to the mysterious realms of the feminine. Achtenberg argues that the caring approach of indigenous women for their families is hardly different from the approach taken by the women of the Northern and Western worlds before their healing practices were institutionalised. (39) It appears to Clough (40) and Murdock (62) that modern women continue to practise their healing vocation silently, without acknowledgement with regard to the time and resources that are spent on performing the roles. (40) Achtenberg classifies this as the institutionalisation and industrialisation of the healing vocation of women. (39) Clough (40) describes this as the double burden that modern women have to carry as they still continue to look after the health of the home while also being integrated into the formal job market. The participants in the current study saw the neglect of women's roles by women and their taking over of the men's role as the same as 'drinking bad water'.

The third critical incident, of the older Xhosa woman who was refusing to rebuild her hut, showed that the older Xhosa women required support, too. Previously, in critical incident 3, she spoke of being left alone with her grandchildren. Her daughter, it appears, continued to enjoy city life, using the child support grant that she was given for her children, who were left with her mother. The other older Xhosa women wanted the older Xhosa woman to stretch herself further, and she could not take it any more. The older Xhosa women appeared not to be aware of the emotional need for support of the older Xhosa woman, as they had daughters-in-law who were brought, as young virgins, into their households. They might also not have been aware of the same emotional need for support that the daughters-in-law had, as they continued to do the hard work of the home and to support the older Xhosa women with doing the physical chores in the home. The young wives in TOC1 had already shown that the daughters-in-law questioned the superior role of the older Xhosa women. This again links with Mashile's perception (138) of the need to support women as they carry out their caring tasks. Kanter (142) expands on the outsider's role and the need for the outsider to contribute to the well-established male-dominated environment. The current study has already alluded to who controls the homes in the Gusi villages. The older Xhosa woman understands that, to keep the tranquillity and the health of the home, she has to keep the man of the home happy and to ensure that he is respected by his young wives. The situation appears no different from that of the male-dominated health institutions, where the CNP

practises what she has been assigned to do in assisting the doctors by acting as a pseudo-doctor for minor health ailments. As Mash (16) explains about the role of the CNP that will continue to be redefined, it is hoped that assuming the role will not distance the practitioner from her caring role. It appears from the current study that all women from the 18 villages of Gusi, including those who were health professionals, required support as they carried out their heavy burden of caring.

The caring approach of the older Xhosa women was complex, because it included experiential knowledge learnt during childhood in preparation for the specific role of being a married woman. This knowledge was validated by the mother-in-law once the daughter married, in preparation for being an older Xhosa woman. This aspect appears to be the knowledge part of the caring. There is, however, more than knowledge involved in this caring approach. There is also the 'feeling/intuition' part of the knowledge. Diana Gibson explains the demanding roles assumed by wives and carers in relation to husbands with chronic illnesses, as their illnesses progressed:

*Contrastingly, their wives increasingly experienced their own bodies as 'open' to that of their husband's illness, as they became unusually aware of and responsive to its smallest changes - they expressed a kind of permeation between the bodies of their husbands and themselves. Thus they had to 'read' it, or to develop a 'feeling' or 'sense' that their husband's blood sugar might be too high or too low - these women as carers became vigilant of every move their husbands made. Boundaries became blurred, even with their daughters developing a similar sixth sense about their father's status of illness.*

(136, pp. 277-291)

It appears that the sense described above is the sixth sense about which the older Xhosa women talked when they said that the mother felt her breast tingling when her baby was not going to be well. She expands on how the women would look at, and dress, their husband's open amputation wounds at which their husbands avoided looking, and which they had rejected as parts of their bodies. The extended role that the women assumed was not far from the role described in some of the accounts that were given by the older Xhosa women in the current study, as they stretched themselves to try and protect the individuals in the home, but most especially the husband.

Achtenberg (39) claims that the caring and healing arena belongs to women who were wrestled away by religious dogmas. The thinking is not far from that of the perception of the chief of Gusi, who regarded the nature of what wrestled the healing knowledge away from

the inhabitants of Gusi. (30) Achtenberg further proposes that the acknowledgement and the siting of the knowledge as a school of practice is essential for generations to come. (39) The man in FG2 suggested that the older Xhosa woman is the cook of the health strategies at home. According to the older Xhosa women, all the strategies of the home are health strategies, as all actions of the home have a direct impact on the health status of the home, hence the older Xhosa woman continues with the many actions that are required in caring for the functionality and the health of the home. (62,137)

Gibson (136) argues that women, as carers, do not receive assistance from formalised home care services. The lack of recognition of the caring of women for the ill and their families has already been mentioned by such researchers as Achtenberg (39), Murdock (62) and Clough (40). This is the situation in which the older Xhosa women found themselves in relation to the health facilities of the 18 villages of Gusi, in terms of which the health professionals first failed to recognise that the women had tried to do something when their relatives were ill, and instead chastised them for using IHK. In response, the women hid their knowledge, and did not inform the health professionals of what they had used or were using. They further showed signs of rebelling against the whole approach, by saying that, as the hospital had brought all the illnesses, the hospital better address them all. The health professionals forgot that, for the older Xhosa women, their first reaction to their relatives was to relieve pain and suffering, using whatever means was available to them. (12,13,168)

The caring skill that helped to maintain the health of the families of the older Xhosa women appeared to resemble the caring and empathy that they hoped to find when they visited the health services of their villages. Unfortunately, it appeared that, for whatever reasons, unlike the older Xhosa women from the villages of Gusi, the majority of health professionals did not see the necessity for developing the interactive reasoning regarding what their patients required from the health service, referring to them being heard and acknowledged as a person who reasons and acts when they are faced with the problem of illness in their families within the home. (3,19,70)

The current study suggests that, for the element of caring to be recognised as an important integral part of a health environment, both the inhabitants of the Gusi villages and the health professionals concerned should design a plan for how to revive the caring element in their health facilities. (168) A good place to start could be to listen to the older Xhosa woman as she narrates the steps taken in caring that she has taken in managing the health problem of the relative that they brought to the health service. The reciprocation should involve explaining to the older Xhosa woman about the biomedical care that is going to be given to their relative.

## **5.7 THE VULNERABILITY OF THE INDIGENOUS HEALTH KNOWLEDGE UTILISED BY THE OLDER XHOSA WOMEN IN THE MANAGEMENT OF HEALTH PROBLEMS IN THEIR HOME SITUATION**

This section addresses aspects that influence the vulnerability of the IHK utilised by the older Xhosa women in the management of health problems in their home.

### **5.7.1 The presence of biomedical care in the 18 villages of Gusi: A blessing and a curse to IHK**

It appears that the introduction of biomedicine to the 18 villages of Gusi has been both a blessing and a curse for the inhabitants of the 18 villages of Gusi, as well as for their IHK. The lack of recognition of IHK by health professionals, as well as the attitudes that they display when patients utilise the knowledge is problematic. Those who utilise IHK appear to do so at their own peril. Patients feel ashamed of talking about what they have used at home, as the health professionals appear ready to ridicule, embarrass or belittle anyone who has utilised IHK. (19,105) This results in the patients and their relatives not valuing IHK, hence they see little need for its use. (7,8,93-98)

The above also has a negative impact on biomedicine and client management, as the history of illness and the process of its management is not well understood by health professionals. This results in the adoption of a nonholistic approach, with those who are close to the health facility showing clear symptoms of their IHK having been weakened, with no replacement with biomedical knowledge. (121) The participants who live far from the facility continue to strengthen their own knowledge and to manage illnesses that are far more complex. (121) The prevailing situation appears to have no solution, as the government of the day continues to implement fractured PHC services that still concentrate on selective curative PHC, even in those services, such as the clinics, that should be offering comprehensive PHC. (12,13)

At the time of the current study, eight clinics had recently been established around the hospital, with a cluster of villages falling under the supervision of each clinic. Linked to the clinics were the community health care workers. All effort had been made to bring the health services closer to the inhabitants of the 18 villages of Gusi. (10,11) The challenge was the type of health care that was offered in the clinics, which in no way resembled the culture and the life of the Amabovane people. (30,43,44) The latest threat to the health knowledge of the older Xhosa woman was the enlistment of community health workers who were young *makotis* (young wives from the 18 villages of Gusi) to work as community health workers under the supervision of the CNP, who did not value the older Xhosa women for using IHK when their relatives were ill. With the implementation of the eight clinics, with the CNPs as their managers and the community health workers as their foot soldiers to link the clinic with

the homes of the Gusi people, the hold of biomedicine had further tightened on the inhabitants of the 18 villages of Gusi. This could be seen as creating an opportunity for the community health workers to work hand-in-hand with the older Xhosa women to assist the CNPs to understand the management of health problems within the home. (10,11) The complexity of the social health determinants to which the older Xhosa women had already alluded in the FGDs showed how ill-suited the PHC service that had been implemented in the 18 villages of Gusi was to the inhabitants of Gusi.

The revitalisation of comprehensive PHC offers an opportunity to explore the IHK possessed by the older Xhosa women fully, starting from the point of how to be a fully functional Bomvane, and assisting them to maintain good health. Health professionals who enter the region will have to learn about the culture, and those who have tried to replace, or to ignore, it in preference for Western culture will need to revive it, so as to assist the health professionals who are newcomers in the area, in order that they might come to understand the culture as soon as they can, in order to foster the health of their patients.

### **5.7.2 Change of family structures: Contribution to the weakening of indigenous health knowledge**

The older Xhosa women complained about the lack of development in the 18 villages of Gusi. Young people were drawn to work in the cities. (30) The education system that had been implemented failed to prepare the younger generation for living the lifestyle that was required of them to live in the 18 villages of Gusi. The grandchildren were the IHK trainees of the older Xhosa women. The girl child moved with her knowledge to the next village, in order to enrich it with the knowledge that she carried with her. The present situation, in which youngsters move to the cities once they finish schooling, leaves a knowledge gap, as there is no one to inherit the IHK possessed by the older Xhosa women. Also now, the daughter-in-law who was practising IHK in the quiet seeks to validate her knowledge through gaining the support of her mother-in-law might also leave to work in the city, die of HIV/AIDS, or build her own home away from that of her mother-in-law, leaving the older Xhosa woman unsupported to practise her healing vocation. (TROC1)

When the parents have died of HIV/AIDS and some of the grandmothers are left with unruly grandchildren, the latter have to assume roles that are beyond their scope of being grandmothers, leaving them little time in which to teach grandchildren about IHK. (28,60) This leaves a knowledge gap, with no trainees (grandchildren) and people who have had their knowledge developed so that they can take over the role of the older Xhosa women (who would normally have been the daughter-in-law). The schools in the area need to take

cognisance of this, and, through the promotion of health (158), develop school projects that are related to documenting knowledge for future generations. (3,7,8)

### **5.7.3 Vulnerability of land: Loss of indigenous herbs and food, resulting in hunger**

The IHK possessed by the older Xhosa women was intertwined with the land, its plants/herbs and its waters, as well as with living entities (i.e. people and animals). (7,8) When a woman was pregnant, the eating of certain indigenous foodstuffs ensured the mother a healthy pregnancy. Discomfort during pregnancy, such as that which was caused by heartburn, was dealt with by using indigenous foods. When a mother gave birth, she danced and mashed her afterbirth in a private place in her garden to fertilise the garden. On her first day of activity after birth, she took the dung of cows that ate the grass in the village that had been fertilised by the many afterbirths from the village children to clean the floor of her bedroom. (30) According to the older Xhosa women, for every illness there was a herb that was readily available to cure illness, as all the women of the village had contributed their afterbirth to fertilise the soil of the village and its plants. (30)

Nowadays, there are new ways of ploughing using fertilisers that, according to the women, poison the soil and the cattle are being replaced with tractors, whereas cattle were once seen as being quite gentle on the soil and continuing to be so, through their dung that fertilises the soil during ploughing. Also, when the women give birth at the hospital, it is not clear what happens to their afterbirth. This might be one of the reasons why the older Xhosa women resist *makotis* (young wives) giving birth in the hospital.

One of the greatest challenges to the area is the syphoning of the young men off to the mines, leaving only women and elderly men in the village. In village life, mainly young men and boys plough the fields. The siphoning off leaves no manpower for ploughing. At present, the men who find work (despite the high unemployment rate) in the cities work mainly as labourers, as the majority are uneducated. This has collapsed the entire economy of the Amabomvane, which used to depend on pastoral farming. (30) Also, the children attend school and no longer watch the animals going to the fields, and no longer eat planted items, leaving the plants in the fields vulnerable to destruction by animals. This causes hunger in families, and makes them depend on the money that their children earn in the cities, which is the main reason why they left the villages. At present, there are unsustainable ways of ploughing that ultimately leave vacant fields unploughed, due to tractors breaking down and there being no one to repair them.

Nowadays, new shops have food on offer of whose medicinal component the older Xhosa women cannot attest, with the food having already been processed, without them nurturing it

during its growth. The buying of food brings hunger, as the older Xhosa women always to have enough money to buy it, instead of ploughing the land to produce one's own food. This brings worry, as the money is soon spent. The biggest tragedy about this is, as the current study has already explained, the lack of sufficient resources (in the form of maize and human capital) to make Xhosa beer for ancestral reverence ceremonies. (30,95-100) This results in angry ancestors, who do not support the health of the home, which leads to unhealthy homes and which, ultimately, creates unhealthy villages.

#### **5.7.4 The patriach management of the 18 villages of Gusi: A threat to the possibility of the evolvment and improvement of the IHK carried by the older Xhosa women.**

The conceptual underpinning of this research is based on the thinking that the IHK carried by the older Xhosa women is not restricted to time, space and extent, but keeps redefining itself according to the challenges and changes that each older Xhosa woman experiences in her home and in her rural environment. (8) The current study has further expanded that the Amabomvane culture is a patriarchal culture. How much space is given to the makoti (young wife) for integrating her own knowledge from her own village and her maternal home into the marriage home is unclear. At the time of the current study, women were still expected to change their way of pronouncing certain words if those words are similar to the names of their husbands, or to that of any man from their husband's side. Women were not expected to enter the kraal, and were expected to avoid certain areas in the hut in order to show respect for the men of the household. (30)

This study had classified the movement of women from one village to the next village as a process that can enhance and improve the amount of IHK carried by the older women. As the young wives are also outsiders to their new homes and the village, it would be expected that, as Kanter (142) has mentioned about the behaviour of outsiders, they will conform to the patriarchal culture and only bring new knowledge that endorses and enhances the status of the patriach in their new marital home.

The danger of the above lies in only the aspects of the IHK that support the patriach being enhanced, neglecting the caring elements of this knowledge that is carried by the older Xhosa women, so that it is not improved, or having the elements that are available used merely to suit the patriach. Many women in certain countries apply certain painful practises on the bodies of young girls to ensure that the needs and wishes of the patriach are supported and because of these ministrations young girls are made to be marriageable material. (171) As the current study is advocating for the emancipation of IHK carried by the older Xhosa women for generations to come, it appears that the evolving component of this

knowledge is not only at risk from western biomedicine, but might also be at risk from the very patriarchal regime that has seen fit to foster its development in the past. Such feminist researchers as Clough (40), Murdock (62), and Achtenberg (39) suggest that, all over the world, women in general have repressed and relinquished their overt healing and caring powers and skills in subjection to the dominant patriarch. Lately, other researchers have been questioning the entire concept of the ethic of caring and its contribution to health care. (172-175)

As has already been alluded to in the current study with regard to polygamous relationships and the constitutional rights of women, women in South Africa need to see themselves as equals to their male counterparts. (159) The study found that the majority of the older Xhosa women from Gusi were uneducated and unaware of their own constitutional rights. As a result, they might have continued enhancing the patriarchal model of the Gusi villages, which sometimes did not work in favour of the women in the area. (30) To remedy the above situation, the current study is advocating for the integration of the constitution to the village debates (*imbizo*) that are chaired by the Chief and into the school syllabus of this area and also the facilitation of the education of both the girl and boy children of the 18 villages of Gusi, this study believes that an equitable system will only be able to be achieved when both sexes are aware of the constitutional rights of all. The toning down of the patriarchal system of the 18 villages of Gusi is required for the rights of all to be respected by all (including both women and men).

#### **5.7.5 Lack of organised village institutional structures that focus on the building and development of the Bomvane culture: Lack of theoretical background to support arguments related to indigenous health knowledge possessed by the older Xhosa women**

The education of the Bomvane person is linked to their land, the elders and the ancestors, and hence to ancestral reverence. (7,8,30,95-98) There is also collective development of the knowledge that appears to be like a maze of cultural knitting that starts in the home, and that becomes further enhanced and refined at village gatherings and during the passage through the different stages of being a Bomvane and of becoming connected to the ancestors. (30,61,95-98) The Bomvane people still celebrate their culture through rituals that are related to marriage, with the boys coming out of circumcision, *intonjane* (girls entering womanhood) and *imbeleko* (celebration of a new-born baby), as well as other rituals to reconcile with the ancestors when the home requires such a ritual. (30) What appears not yet to have happened is the proclamation of the knowledge for further open identification and development. Whatever development occurs, happens in informal spaces. The cultural

practice of the Amabomvane can exist, but it is either not acknowledged by outsiders, or is being eroded by all the above-mentioned challenges. The Chief believes that the following three specific areas have weakened and eroded the Bomvane culture and the IHK in the 18 villages of Gusi:

- the Christian religion;
- education; and
- health.

The three areas have a clear institutional presence amongst the 18 villages of Gusi (in the form of the hospital and the eight clinics, the Dutch Reformed Church, and the over 20 primary and high schools present). None of the institutions, according to the Chief, draws its underpinnings from the Bomvane culture. Instead, it appears that each one attempts to erase from the minds of the Bomvane people their own culture, as it appears to be that for the Bomvane person it is not suitable to have that culture. (30) This thinking appears not to be far from the thinking of other indigenous people who see their knowledges as being vulnerable to Western cultural influences. (7,8) The influences of education and religion that do not appreciate the essence of what makes one a Bomvane appear to be neglecting the contribution that young people of Bomvaneland can make to their own culture. Instead, once the youngsters finish their schooling locally, they tend to leave the 18 villages of Gusi for the cities. Those left behind tend either to ignore the Bomvane culture or to chastise those who appear to be aligned with it. The lack of a critical mass for the development of the Bomvane culture is a threat to the continued existence of health knowledge. (7,8)

The health knowledge that is possessed by the older Xhosa women from the 18 villages of Gusi is intertwined with the culture of being a Bomvane. As the older Xhosa women see the culture dying, they feel that their hands are tied and they are angry and frustrated. (FG4) The study has not only considered the changes that have impacted negatively on the IHK from the Christian religion, education and health, but also those that have come about as a result of modern-day existence. The solution to the latter rarely emerge from previous experiences, but are marked by an immediate response that is governed by a need for instant solutions, using the most modern schools of thought as their knowledge base and literature. (32,39,40,62) The above is a challenge for the Bomvane culture, as it is characterised by knowledge that is carried by word of mouth. The chief of the 18 villages of Gusi has warned against approaching the Amabomvane culture with the aim of cleaning off the slate the very attributes that are associated with being a Bomvane. It was in terms of such a regard that he suggested the integration of knowledges. The chieftain spoke of a backward and forward motion (14) as a solution for bridging the gaps between knowledges,

ensuring that valuable lessons and solutions of the past are integrated in the scope of practice in present times, including the health scope of practice. Perhaps by bringing health issues, including health determinants, to the *imbizos* of the chief, the 18 villages of Gusi can move forward, while promoting the culture of the Amabomvane as the key culture that underpins the three aforementioned institutions (religion, education and health). The Amabomvane people can be empowered to be the active participants in terms of their own health, culture and religion, and to continue to develop the theory that underpins their very existence.

#### **5.7.5 A knowledge carried by word of mouth: Neither documented nor researched by Western methods of conducting research**

The risk to the sustainability of the IHK possessed by the older Xhosa women from the 18 villages of Gusi has already been outlined. (7,8) It has already been demonstrated by the 2 FGs that were close to the hospital how they avoided talking about IHK, and how they maintained that they were no longer using such things. The fact that the carriers of the knowledge are illiterate means that the knowledge stands no chance against biomedicine, which is structured, and which has a clear curriculum. The vulnerability of IHK has already been outlined in the literature review and in the findings of the current study. (7,8) Such authors as Clough (40) have challenged researchers on the choosing of what is classified as topical research questions, and on the fact that they emphasise the existing status of entrenching the existing models with valid researched information. New voices that want to increase the amount of attention that is paid to such vulnerable groups as women, children, disabled people and indigenous people struggle to attract attention and funds for the associated research. (82) Katzellenbogen (82) complains that, in South Africa, in the past, most of the research conducted in the health field focused on quantity rather than on quality and was driven by pharmaceuticals, in partnership with schools of medicine, in terms of trials of efficacy (RCTs). Hardly any studies, including community and public health-orientated research, focused on the accessing of quality care. (82)

The older Xhosa women are dying, and the younger generation is starting to fear their association with their IHK. It is suggested that, with the revitalisation of PHC, one of the areas on which to focus should be the revival of the cultural identity of the Amabomvane people and of that of other cultures carrying IHK. To remedy the situation, it is suggested that the model should focus on the very three approaches (i.e. education, health and religion) that appear to have destabilised the IHK carried by the older Xhosa women and the Amabomvane culture. (30) There is a need to acknowledge the knowledges that are held by the Amabomvane people as important for their health status and progress.

When the above happens, cultural issues that appear to undermine the constitutional rights of each grouping should be studied carefully for the meaning of that culture to the whole group (157) regarding such practices as the administration of corporal punishment to children, the first entry of young girls to marriage beds, and polygamous marriages. The possibility of replacing that culture with a culture that supports the rights of all members of the village should then be considered.

## **5.8 THE POSSIBILITY OF OLDER XHOSA WOMEN STILL PLAYING A ROLE IN THE MANAGEMENT OF HEALTH PROBLEMS WITHIN THEIR OWN HOME**

Achtenberg speaks of how women were originally born as healers, and how the knowledge was wrested from them, and institutionalised and industrialised in the health institutions. The findings of the current study show a situation existing in the 18 villages of Gusi, whereby some health knowledge is still in the hands of the older Xhosa women. The challenge is that their health knowledge is vulnerable, as has been shown in the findings made in relation to FG1 and FG2. Over time, more complex conditions have been brought about that challenge the older Xhosa women, combined with a lack of clarity as to how the conditions should be managed, making those who are farther away from the health facilities capable of seeing themselves managing conditions that are quite complex, and having to cope with some complications caused by others, in the absence of support from the health services. Those who were closer to the hospital found themselves in a situation in which they were losing their skill in practising IHK, as they took all their health problems to the health facility.

The older Xhosa women in FG3 and FG4 confirmed the assumptions that were revealed in Khayelitsha, according to which it was proposed that, generally, health problems, and particularly minor health ailments, could be managed and contained within the home, with the older Xhosa women playing a key role in this regard. The IHK carried by the older Xhosa women with regard to health determinants, the minor health ailments and the health problems that required one to seek help from other health practitioners, as well as their caring attributes, could serve as an asset to the proposed revitalisation of PHC services. (160)

Said knowledge should be used as a starting point for the development of PHC services in the area. The current study avoids using such terms as the integration of this knowledge with the biomedical system that exists in the area. (116) The biomedical system found amongst the Amabomvane people residing in Bomvanaland, with their distinctive lifestyle and disease patterns, includes a maze of strategies of how to tackle already existing disease. (7,8,30,100,104,107) The older Xhosa women proposed that, for every illness of somebody

born in the 18 villages, there was a herbal remedy. The proposition of the older Xhosa women should be validated, and the herbs that can assist with the ailments of the people from the villages of Gusi should be nurtured. The older Xhosa women need to be awarded the status of being the custodians of such health knowledge. Abrahams (71) is of the opinion that, in Southern Africa, even up until present times, the interest that health scientists have shown in IHK has revolved, and is continuing to revolve, around how much harm the knowledge does to the patients concerned. She further suggests that, in keeping with the idea of the African Renaissance, there is a need to shift the emphasis towards developing an understanding of, and a recognition for, the value of IHK. Buhrmann speaks of the urgent need for the African world view to be respected, and for the health knowledge carried by the older Xhosa women to be regarded as part of the African world view. (32,93-98) Health systems in the area that are prepared to join hands with the older Xhosa women in the area of the management of health problems in their own homes will have, first, to learn and understand what being a Bomvane comprises, before tying it in to the health status of the Bomvane people.

Cognitively, indigenous people tend to place greater emphasis on the construction of models in which multiple strands can be accommodated to make an interacting whole. (45,72,77,78) The older Xhosa women resisted talking only about disease. Like the older Xhosa women in Khayelitsha, they saw disease and how it was managed as being linked to the existence of unruly grandchildren and troublesome husbands, as well as to the absence of the middle generation, along with continuous concern about the long-term effect of undermining their skill of looking after the health of the home. To them, by the time that a disease manifested itself, illness had already been present for quite some time, with, usually, the illness being linked to social health determinants. They saw their role of maintaining the stability of the home as playing a huge role in preventing some of the social health determinants, especially those related to growing children, in check. It appeared as though the older Xhosa women had rescinded the Alma Ata Declaration of 1978 (12,13), and the Ottawa Charter (111,112,132-135) encompassing most of the facets of the Declaration. They went further to claim that the area of cultural identity in which one functioned should contribute to one's cultural identity, and that the lack of contribution to such identity was indicative of a lack of wellbeing. (7,8,30,116)

The nearest assigned PHC facility was the clinic. (10,11,12) The clinics were managed by a CNP, who, in the majority of cases, were from the 18 villages of Gusi. As the plan to revitalise PHC services in South Africa appears to be set to take off (160), the CNP, who acts as a pseudo-doctor in screening patients at the primary level of care and who manages

minor health ailments, can be seen to be at the helm of such vitalisation. (16) The practitioners were some of the health professionals about whom the older Xhosa women of Gusi villages complained with regard to them being chastised when they brought a person to the facility after unsuccessfully treating a health problem at home. Mash (16) explains that the role of CNPs will continue to grow and that it will be redefined in establishing the PHC services. The current study perceives that the CNP has more or less the same status as do the elite Xhosa women, who are consulted when the older Xhosa women's strategy for the management of health problems within the home situation has failed.

The other community-based individuals who worked closely with the CNP in the eight clinics of the Gusi villages were the chiefs, chieftains and government councillors, who were like government administrators in the villages. Lately, community health workers had been introduced (160), who were linked to the eight clinics under the supervision of the CNP who managed the clinic. Those who had constant direct connection with the homes were the community health workers in the eight clinics of Gusi, who were usually young married woman, who were like daughters-in-law to the CNP, who, usually, was quite an elderly person close to retirement. (19)

Chalmers expands on an explanation about the challenges facing the middle generation of women, especially in matters of birth (139), stating that they are usually caught between the demands of having to conform to modern birth methods, while at home their paternal parents expect them to conform to the cultural rules of the home. (139) The current study has shown how confusing the status of health management was to the middle generation of women residing in the 18 villages of Gusi. The present study has highlighted the following four different situations in which the situation is played out:

- that in which the young wives whom the researcher encountered during community entry to the hospital swung between using IHK and biomedical care, without taking sides (see Appendix 6);
- that in which the young interpreters took the patients out of hospital in order for the latter to access IHK (TOC3);
- that in which the young *makotis* (wives) were fed up with being controlled by their mothers-in-law, as was witnessed in transitional conversation 1 (TOC1); and
- that in which the young wife (the daughter-in-law to one of the elitist older Xhosa women) revered her mother-in-law and wanted to follow in her footsteps of becoming an expert in using IHK as she grew older.

If the community health workers in the 18 villages of Gusi were part of the above-mentioned group of people, it appeared that they, too, needed to be supported before they could re-enter the homes of the Gusi people to conduct their community health work. At the core of the support was improving their understanding of how the older Xhosa women defined health and illness. The two other groups of people who were consulted by the older Xhosa women when their strategies had failed were the elite Xhosa women and the traditional healers. The traditional healers were not included in the current study. The majority of the elite Xhosa women did not discuss referring to traditional healers first, but to the hospital. The granddaughter of one of the elite Xhosa women said that her grandmother failed to see the need to refer patients to traditional healers, but only referred a patient to the hospital once her own strategies had failed. The elite Xhosa women were encouraged to join hands with both the older Xhosa women and with the community health worker. The CNP needed to develop a bridge of support, so that the three forces (the older Xhosa women, the elite older Xhosa women and the community health care worker) could strengthen the quality of health care administered at home.

The older Xhosa women from Khayelitsha had a problem in them being seen as managing only minor health ailments in the home. Having explored the key research question within the study sample, the current researcher tends to agree with the older Xhosa women that the home should be seen as a locus of control for the prevention of, and for the health promotion for, all health problems within the home situation. (82,132-135) In terms of health promotion and disease prevention, the older Xhosa women would need to be supported as to how to manage all health problems that were managed within the home. (82) This study suggests a PHC model as a means of supporting the older Xhosa women in the management of health problems within their home situation. (10,11)

A bridge of caring should be built between the home and the PHC services (i.e. the clinic) for the management of health problems within the home, in relation to which the older Xhosa women should play a pivotal role.

## **5.9 THE STUDY LIMITATION**

The limitations of the current study were as follows:

- a. The study attempted to remain true to its nature of being exploratory and descriptive, because the older Xhosa women's description of health and illness, as well as the linking of this to the health problems that they managed within the home situation was quite holistic, encompassing and broad. Different facets of the study, such as the concept of functionality as a yardstick for measuring health and illness, or the mothers

of children sensing in their own bodies when their children were ill, as well as the testing of some of the herbs for their pharmacological reaction, require deeper investigation in follow-up studies.

- b. The focus of the study was on older Xhosa women regarding the management of health problems within the home. The contribution of the other family members to how they saw their role in terms of the management of health problems within the home situation was not explored. Such input could, perhaps, have brought another perspective to the study, which might be considered during the piloting of the rural PHC model.
- c. The two lists mentioned by FG3 and FG4 of the health problems that they managed within the home situation should not be seen as final. The older Xhosa women omitted such health problems as bone fractures and mental illness. A more comprehensive list will need to be developed during feedback workshops and follow-up studies.
- d. The researcher, though a Xhosa, is not a Bomvane. Thus, perhaps it was not possible to gain access to, or even to notice, some of the cultural nuances that could have brought a deeper understanding to the interpretation of the older Xhosa women referred to in the research question. The older Xhosa women essentially saw her as an outsider. In contrast, this might also have been an advantage, as the older Xhosa women might have been more open to her as an outsider. This raises questions with regard to exactly which method to follow in conducting and interpreting the lived experiences of indigenous people by an outsider. Follow-up studies should be conducted by local researchers in order, possibly, to gain more accurate information and to be able to interpret the cultural nuances more accurately. The study, however, did make use of the services of a research assistant who was a Bomvane.
- e. The retrospective nature of the study meant that the older Xhosa women had to recall the IHK that they utilised for managing health problems within the home. They might have forgotten some of the health problems that they manage within the home situation. Once the elite older Xhosa women become active participants in the rural PHC model, they are likely to be more willing to share the knowledge that they carry and to utilise it in managing critical incidents, and will most probably also be willing to be observed as to how they manage them.
- f. The majority of the participants lacked any formal education. Though the researcher conducted the discussions with the older Xhosa women in the Xhosa language and in the homes of the older Xhosa women, questioning the older Xhosa women about the health problems that they manage at home might have been limiting. In future, such methodologies as observation and documenting practices could be used as an alternate modus operandi.

- g. Perhaps the greatest challenge of the study lies in its attempt to suggest the integration of IHK with the existing biomedical system in the 18 villages of Gusi. The danger of this is that IHK can only serve as a mere add-on to the existing biomedical health care system. The older Xhosa women expressed a belief that their health status could only be reclaimed and restored if their identity as Bomvane was restored. The suggestion is that the starting point for the rural PHC model is to strive towards the promotion of the primary health determinants that will restore the identity and the dignity of the Amabomvane people. Once this happens, they can play an equal role with the health professionals in building a health model for the inhabitants of the 18 villages of Gusi.

#### **5.10 CONCLUDING STATEMENT**

The discussion of the demographic details and the contextual and health-related factors influencing the management of health problems by the older Xhosa women demonstrated how the Amabomvane culture had designed a model for health maintenance, and for the prevention of disease, by counteracting the social determinants of health. The older Xhosa women saw awareness of their cultural identity as an indicator of wellness. At the helm of this preservation of the health of the home is the older Xhosa woman, knitting a mosaic of skills, knowledge and attributes for the family. The home is the nucleus in which health is maintained and illness is contained, and the older Xhosa women play a critical role in ensuring that family members obtain optimal health status.

The development of the biomedical health care services within the 18 villages of Gusi had brought both rewards and tensions to the area, as the older Xhosa women struggled to find a place for their knowledge within the new health system. Their lack of educational tools appeared to distance them from modern health practices and knowledges that appeared to be taking over control of their scope of practice. Other threats, such as the migration of the younger generation to the cities, resulting in the further collapse of the Bomvane rural economy, appeared to deepen the struggle that was faced by the holistic approach to health followed by the older Xhosa women.

The introduction of the CNP as the manager of a clinic, and the minor health ailments handled, as well the link of such to the community health worker might assist in supporting the older Xhosa women in managing health problems within their own homes. It is hoped that such support can assist in positioning the IHK held by the older Xhosa women correctly. The current study proposes a bridge of primary care joining the homes of the 18 villages of Gusi to the 8 clinics. The proposed revitalisation of both the PHC and the NHI needs to strengthen the development of this bridge of primary care.

## **CHAPTER 6: CRITICAL STUDY OUTCOMES, THE PROPOSED PRIMARY HEALTH CARE MODEL AND RECOMMENDATIONS**

### **6.1 INTRODUCTION**

This chapter will identify and outline critical research outcomes that emerged from the results of the current study. What has emerged from the definition of health and illness, including the determinants of health and illness, as described by the older Xhosa women, will be presented, and a suggestion will be made to use this as a way in which to determine the status of health and illness of the inhabitants of the 18 villages in Gusi. The health problems that are managed by older Xhosa women in their home situation will be outlined, including a description of the herbs that they use to manage them. An integrated PHC model will be suggested regarding how to manage the health problems. Recommendations will be made to key stakeholders as to how the IHK carried by the older Xhosa women can be integrated into PHC and health science education. This chapter will finish with a concluding statement to the study.

### **6.2 CRITICAL RESEARCH FINDINGS AND THEIR IMPLICATION FOR THE STUDY**

This section will cover the critical research findings and their implications for the IHK possessed by the older Xhosa women regarding the management of health problems in their home situation. Below are listed the critical areas that will be covered as an outcome to the exploration conducted in terms of the main objectives of the study:

- the emerging model of health and illness definition, from the perspective of the older Xhosa women, including the use of functionality as a yardstick for measuring wellness;
- the health problems that are managed by the older Xhosa women within their home situation; and
- the caring attributes of the older Xhosa women, amounting to the circle of caring.

#### **6.2.1 The emerging model of health and illness definition by the older Xhosa women**

A clear definition of health and illness emerged from the data obtained in the study. Regarding the nature of health, the following issues are covered in the definition:

- the determinants of health;
- the nature of illness;
- the determinants of illness; and

- the use of functionality as a yardstick against which to measure issues of health and wellness.

### **6.2.1.1 Definition of health and illness**

With regard to the definition of health, the older Xhosa women not only defined health, but also illness. If the communities are to uphold both health and wellness, they need to understand and to describe the other side of the coin, which is illness. (7,8,45) The results from the current study included the definition of illness as a good health promotion and prevention of disease strategy. (82,132-135) Communities can know and understand what they need to prevent in their communities. (10,11) This study, therefore, firstly suggests that, during the 2015 revision of the health definition (45), WHO should also develop a definition of illness to accompany the definition of health, as it is deduced from the results of the current study that the formulation of such a definition would lead to the further endorsement of health promotion and disease prevention strategies.

The older Xhosa women added three elements to the existing WHO health definition, namely: food security; healthy children and families; and peace and security in their villages. Secondly, the study proposes that the three elements mentioned should be included in the revision of the WHO health definition in 2015. (45) The three elements are not only important for the 18 villages of Gusi, but also for the rest of humanity. (94-98) Finally, the study proposes that a definition of health would need to be seen as a flexible entity that requires its final indicators to be clarified and developed within each particular context, with the aim of the people in the context taking ownership of the definition. A universal health definition that lacks such flexibility is a drawback, as the health context of the peoples of the world is not universal, and, furthermore, the systems that are currently being used to determine health follow the biomedical health system. (7,8)

The health approaches, as well as the definition that underpins the indigenous peoples of the world, have still to be considered. (7,8,43,44) By defining the degree of health and illness present in their 18 villages, the older Xhosa women have started to make a clear contribution in this regard. South Africa is currently re-engineering PHC, together with a new health plan. It is hoped that the three elements and the definition of illness can be included when considering the rural health plan for the 18 villages of Gusi. (150,167,176) Table 6.1 below outlines the critical aspects that emerged from the definition of health and illness by the older Xhosa women.

**Table 6.1: The critical aspects that underpin the health and illness definition produced by the current study**

Definition of health	Determinants of health	Definition of illness	Determinants of illness
<ul style="list-style-type: none"> <li>• Absence or presence of disease</li> <li>• Healthy pregnancy and healthy children</li> <li>• Food a key contributor of health to the home</li> <li>• Presence of peace, happiness, wellness and support for one another in the village</li> </ul>	<p>Positive:</p> <ul style="list-style-type: none"> <li>• Happiness and wellness</li> <li>• Connected to ancestors and God</li> <li>• Food production</li> <li>• Production of Xhosa beer</li> </ul> <p>Negative:</p> <ul style="list-style-type: none"> <li>• Presence of worry</li> <li>• Subjection to being troubled by men/husbands</li> <li>• Subjection to being troubled by children</li> </ul>	<p>Interpreted within a perspective that is both physical and emotional</p> <ul style="list-style-type: none"> <li>• Absence of the following: money; sanitation; running water; and electricity</li> <li>• Migration of adult children to work in the cities</li> </ul>	<p>Doing poorly at maintaining the following:</p> <p>body; spirit; children; mother; and other family members, due to:</p> <ul style="list-style-type: none"> <li>• the absence of work;</li> <li>• loneliness;</li> <li>• the migration of children to the cities;</li> <li>• substance abuse by children (smoking and drinking);</li> <li>• the inability to produce food and Xhosa beer; and</li> <li>• the lack of sufficient time for ancestral reverence</li> </ul>

When comparing Table 6.1 with the contents of the essential elements of primary care and the essential building blocks for PHC,(10,11,12) it appears that some aspects, such as maternal and child health, nutrition, water and sanitation, and diseases are contained in both definitions. The older Xhosa women go further to describe the underlying social and economic determinants that cause poor health. (10,11) To them, it is about addressing the underlying social health determinants that could assist them with reclaiming the health balance in their villages.

### **6.2.1.2 Using functionality as a yardstick for wellness**

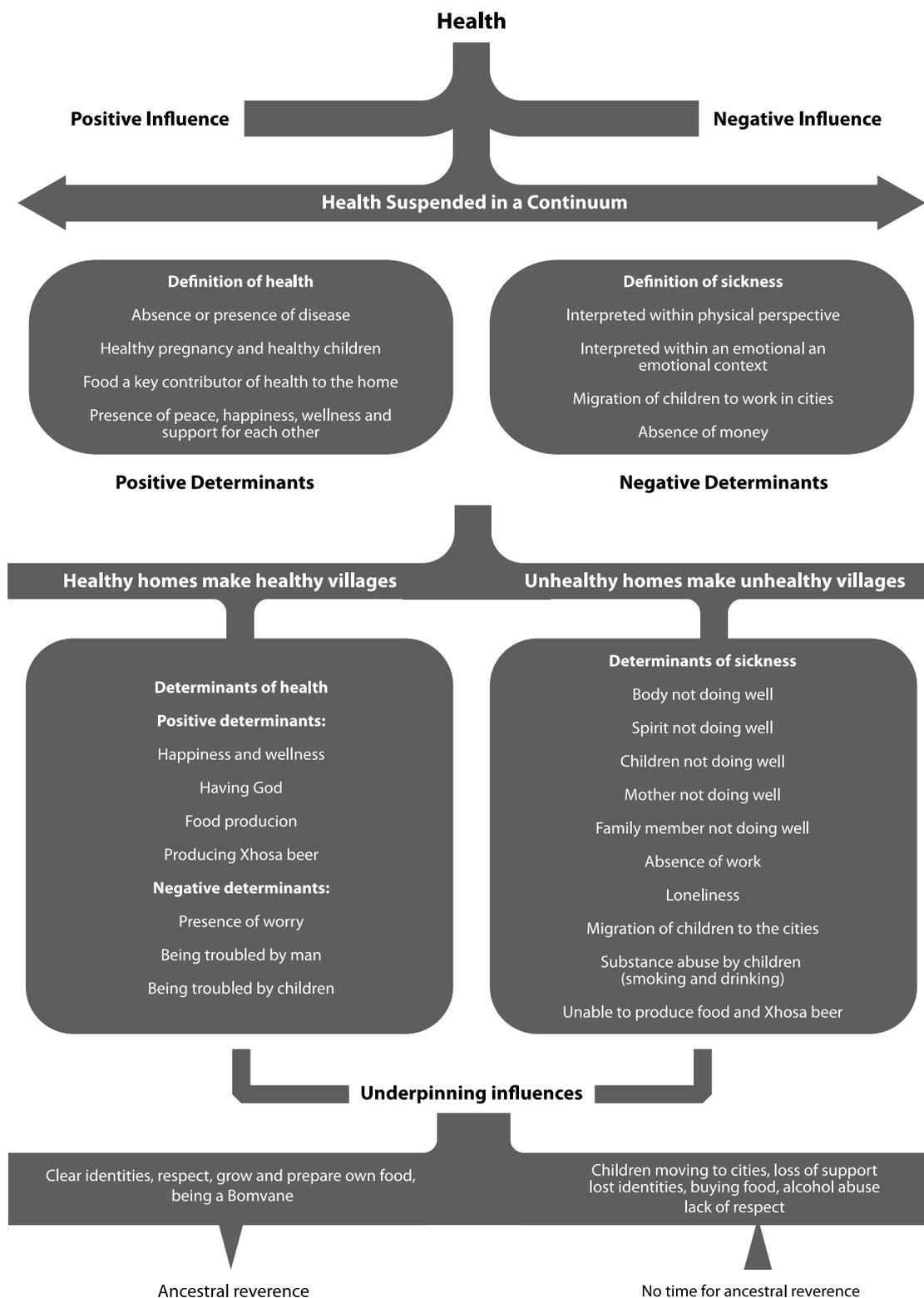
For the older Xhosa women in the study, as it was for the Maori (42), by whom health was measured according to their participation in tribal activities, being included in family celebrations and the ability to make Xhosa beer for ancestral reverence served as a yardstick for wellness. (30,93-97) Being healthy entailed being fully engaged in the functions of the Amabomvane people. This is the yardstick that they used for measuring the health

status of an individual in their villages. This concept is similar to that which is found in the ICF (see Figure 2.1), which proposes that the limitation of one's activities and one's participation is linked to both environmental and personal factors, and that the two factors will ultimately determine the status of the person's health and disability. (147) The challenge with the ICF tool is that, often, no consideration is given as to who the person is and regarding what identity s/he brings to their health status, whereas the identity is to be used as a yardstick for measuring the full community integration of the person. For example, when an older Xhosa women discusses going to work, consideration must be given as to what type of work an older and younger person, as well as a child, does in one of the 18 villages of Gusi. The above has a huge implication for health professionals who are coming from outside Bomvaneland, and for those who are trained in Western medicine who do not understand the culture of the Amabomvane people, including the enhancement of the Bomvane culture by that person as a way of contributing to his/her health and wellness. This links to Maleana's suggestion that health promoters and disease prevention in rural South Africa need to be cognisant of the contribution made by culture to the health of rural South Africans. (43) Health professionals who are outsiders will need to understand the cultural implications of being a Bomvane in order to deliver health effectively in Bomvaneland. (43)

This study also charts a new pathway for the rehabilitation professions. WHO defines rehabilitation as enabling disabled people to reach and to maintain their optimal functional levels, by providing them with the tools that they require for attaining independence and self-determination. The ultimate goal of rehabilitation is full community integration. (169) Final-year medical students from the Medical Faculty of Health Sciences (MFHS) at Stellenbosch University (SU) are already being sent to the hospital in the area. It is proposed that the MFHS should include, in the multidisciplinary and interprofessional student teams visiting the area, final-year students who are in the rehabilitation professions (i.e. physiotherapy; occupational therapy; speech therapy; and human nutrition), in addition to medical students.

Once the said students have become part of the integrated team for the revitalisation of PHC in the area, they will need to understand what the functions of being a Bomvane are, and what the key indicators are for this level of functionality. Consequently, the indicators concerned will be used for rehabilitating their clients into the community in the Bomvaneland area. Figure 6.5 below consists of a flowchart that depicts a conceptual understanding of the factors influencing health and illness, according to the older Xhosa women.

## A conceptual understanding of factors influencing health and sickness according to the older Xhosa women



**Figure 6.1: The model of health and illness from this study.**

## 6.2.2 The health problems that are managed by the older woman within the home

The current study identified three categories of health problems that were managed within the home situation, which are:

- social health problems;
- minor health ailments that can be managed at home; and
- other health problems that require referral outside the home.

The three categories are discussed below.

### 6.2.2.1 Social health problems

Globally, there is a problem regarding the implementing of PHC as a strategy in its entirety, especially in low-income countries, where it is most needed (10,11,12); instead, selective PHC has been an interim chosen strategy. Such health care is mainly what is offered at present by the primary care services that are common in low-income countries, and in such rural areas as the villages of Gusi. Not implementing PHC to its fullest has challenges of the revolving door syndrome, as social health problems that are commonly the cause of disease are left unaddressed. (17,18) Primary and secondary social health problems emerged from the findings in this study, as are outlined in Table 6.2 below.

**Table 6.2: Primary and secondary health problems identified in the study**

<b>Primary and secondary health problems</b>
Primary social health problems
<ul style="list-style-type: none"> <li>• Lack of respect</li> <li>• Substance abuse</li> <li>• Alcoholism</li> <li>• Not planting and ploughing food</li> <li>• Poverty in households</li> <li>• Presence of struggle</li> <li>• Lack of peace and security.</li> <li>• Lack of motivation</li> <li>• Unruly children</li> <li>• Money problems (financial concerns)</li> <li>• Absence of health</li> <li>• New diseases</li> <li>• Not brewing Xhosa beer</li> <li>• Making neither sufficient time nor resources available for purposes of ancestral reverence</li> </ul>
Secondary health problems
<ul style="list-style-type: none"> <li>• Absence of work</li> <li>• No projects on which people can work</li> <li>• Absence of clean running water and sanitation</li> <li>• No electricity</li> <li>• Lack of money</li> <li>• Non-receipt of old age pension</li> </ul>

In relation to the primary and secondary health problems noted in Table 6.2 above, the older Xhosa women from Bomvanaland saw some of the social health determinants, such as peace in the home and security in the village, as well as the production of food, as their domain and that of the village, which could serve as an asset that could be used in revitalising PHC.(160) The current study suggests that the older Xhosa women should be supported in their roles (138), as were the older Xhosa women, who were supported in Khayelitsha by the community health forums. (3,19)

#### **6.2.2.2 Minor health ailments that can be managed at home**

The current researcher wishes to propose using the list outlined in Table 6.3 below as a starting point in assisting the older Xhosa women to define their scope of practice within the home situation. The aforesaid list itemises the minor health problems identified that could be managed by the older Xhosa women at home.

**Table 6.3: List of minor health ailments that could be managed within the home**

Facial pimples	<i>Amaqhakuva obuso</i>
First stool of an infant	<i>Ituwa yokuqhala yomntwana</i>
General cough	<i>Ukukhohlela okungephi</i>
Head lice	<i>Intwala zentloko</i>
Blocked nose	<i>Umfinxane</i>
Mouth blisters	<i>Amandyunguza omlomo</i>
Childbirth	<i>Ukuzala</i>
First baby rash	<i>Ishimnca</i>

The above list should be verified and validated by the CNPs in the village health forums, and by the family physicians and general practitioners. Thereafter, a strategy as to how the minor health ailments can be managed within the home, with the older Xhosa women playing a key role in this regard, should be developed.

#### **6.2.2.3 The herbs that are used by the older Xhosa women in managing health problems within the home**

Approximately 32 herbs and approaches were mentioned by the older Xhosa women for the management of health problems within their home. They believed that, for every person born in Gusi, there were herbs that were available for the treatment of illnesses. An attempt has not been made to translate the names of the herbs into English, as, the researcher did not know what some of them were and what they looked like, as well as their pharmacological

effect on the health problems that were mentioned by the older Xhosa women. Listed in Table 6.4 are the herbs used by the older Xhosa women.

**Table 6.4: A list of herbs and approaches used by the older Xhosa women to treat the health problems that they experienced within the home**

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*Umkhamelo; itshungu; inkondlane; umuncane; unogangatshange; umncephe; unohawuzela; mthene; mpinda; umsobowehlathi; mafumbuka; amanziolwandle; uthulilengca; ubuhlungu; isichakathi; isikhikhi; ingxozela; tsasela; impuzizethanga; ukuthonjiswa; umhlonyane; isindiya-ndiya; sampontshane; Imputshi yehashe; umthombothi; impepho; ityholo; amafutha ehagu; umafumbuka; isihawu-hawu; isivumba mpunzi; ixolo lo umnga*

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The current study suggests that the process of revitalisation of PHC in the area should start with understanding the IHK possessed by the older Xhosa women in managing the health problems in their homes. (7,8) It is important that indigenous herbs that grow in the area are investigated, as the older Xhosa women have an idea that, for every illness of a person born in a Gusi village, there is an existing herbal remedy. The above list is probably not comprehensive, as the majority of the elite older Xhosa women were reluctant to mention the herbs that they used and the conditions that they managed.

Medical and other health science students could first work with the elite older Xhosa women in developing a comprehensive list of herbs for the illnesses that they manage within the home situation. Once they have a comprehensive list, they should work with the pharmacological departments of the University of the Western Cape and the University of Cape Town to test the herbs pharmacologically and to obtain the rationale why the older Xhosa women use them for the illnesses that they have mentioned.

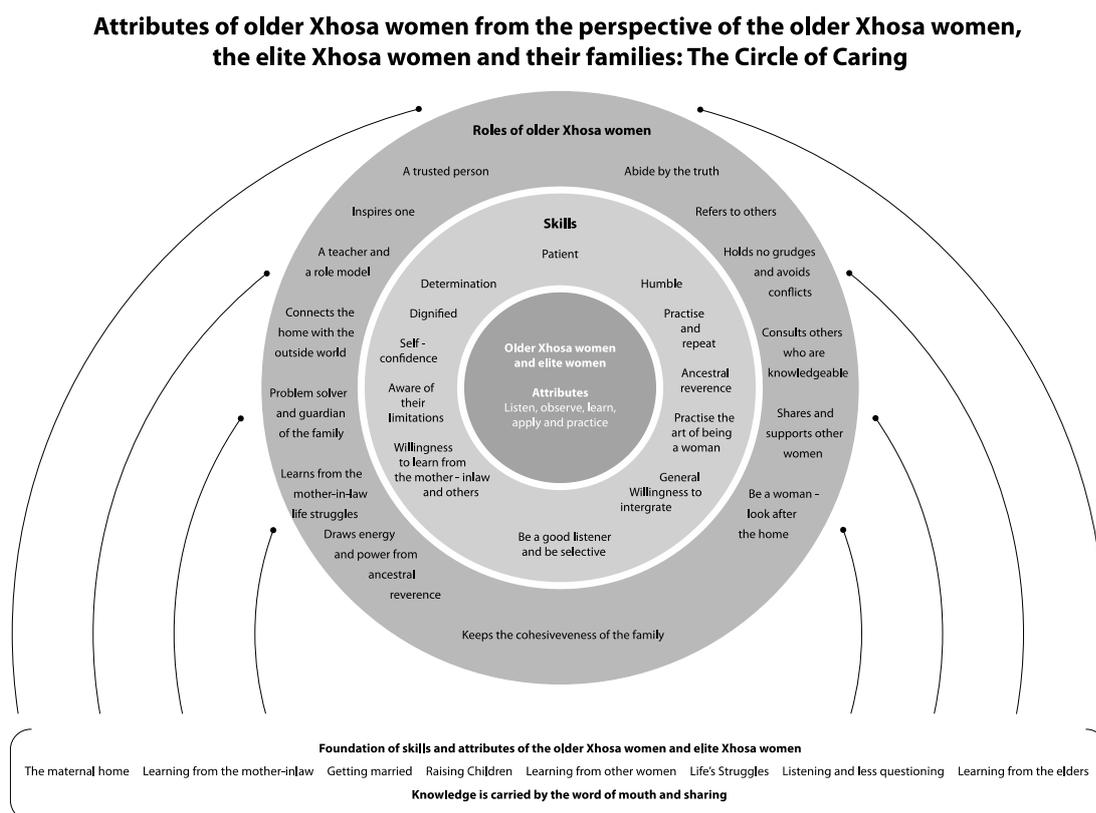
Providing training opportunities for medical and health science students in said area should assist students to learn about the people of the area, and then about the definition of health and illness, the health determinants, the diseases that are prevalent in the area, and how the people in the area manage the diseases identified. The ultimate goal for students is to see how they can assist people to reclaim their highest status, which is to be a Bomvane. Doing so will assist the students to bridge the gap between the orthodox Western and African sociocultural context. (146) Serpell (146) argues that education should afford students the opportunity to test formal Western theories against the African reality, and it should prepare them for the challenges that they will have to face at work after graduation. For students to be effective, health professionals within an African context and indigenous communities should provide opportunities for comparing and integrating academic theories and perspectives with indigenous interpretations of experience.

### 6.2.2.4 Health problems requiring referral to an outside person for advice and further management

Thirty-one (31) health ailments were mentioned by FG3 and FG4 as having given rise to critical incidents, and as having to be referred to an outside person for advice and further management (see tables 17 and 18). This list should further be strengthened by including bone fractures and mental illness, as well as any other health ailment that has been omitted by the older Xhosa women. Once validated, a decision needs to be made with regard to the role that the older Xhosa women can play in solving the health problems, and to which point and to whom amongst the health care providers in the 18 villages of Gusi they should refer patients.

### 6.2.3 The caring attributes of the older Xhosa women: the circle of caring

In describing the current study, it has been made clear that the older Xhosa women use a myriad of caring skills to ensure the management of health in the home. Such skills assist the older woman in her management of the health problems within the home. Figure 6.6 below outlines the caring skills and attributes of the older Xhosa women in the study.



**Figure 6.2: A flowchart showing the caring skills and attributes of the older Xhosa women**

Figure 6.2 above shows that the skills and attributes of the older Xhosa women appear to be underpinned by the five components that are integral to knowledge and information

exchange, namely listening, learning, observation, application and practice. This implies that the health knowledge that is carried by the older Xhosa women is always evolving. There is a process of listening, observation, learning, application and practice. The middle generation (consisting of the *makotis*) goes through a process of validation of the knowledge by listening to, and learning from, the mother-in-law. The holders of the knowledge (referring to the girl child who will be married into another village) are quite mobile individuals, conveying knowledge from one village to the next village. The men of the village describe the women as the cook of all the strategies in the home and, unlike westernised women, who still practise such a role, but who also participate in the industrial world, as ending up with their resources being spread quite thinly. (39,40,62) For the older Xhosa women, their roles as women were clear, namely to manage and look after the health of the home. The current study has clearly demonstrated that, for the older Xhosa women, the role is starting to be a challenge, due to the introduction of Western medicine, and the changes that are happening in their family structures and in the community.

Lately the area of caring is a contested terrain requiring critical attention to who defines these differences as well as their practical implications. Feminist authors such as Cloyes and Cockburn (172,173) challenge the notion of caring and see it as being situated on inequalities within an oppressive hegemonic arrangements of power. While others such as Dybicz and Bradshaw (174,175) caution that true caring is usually underpinned by qualities such as democracy, reciprocity and collaboration. These authors see caring as important element in the facilitation of health and wellbeing. .

### **6.3 A PROPOSAL FOR A RURAL PRIMARY HEALTH CARE MODEL FOR THE 18 VILLAGES OF GUSI FOR THE MANAGEMENT OF HEALTH PROBLEMS WITHIN THE HOME**

South Africa is promising to re-engineer its health system through a multibillion rand scheme, in which the management, staffing, infrastructure and equipment at public health facilities will be overhauled and a National Health Insurance (NHI) fund set up. (167) Together, and aligned with this, is the re-engineering of PHC that the South African government is promising to its PHC user citizens. (160) The government acknowledges that insufficient attention has been paid to the implementation of the PHC approach, especially in terms of the lack of focus on the health of populations and the measurement of health indicator outcomes. The re-engineered PHC strategy promises to strengthen the district health system by managing the basics. The basics include an emphasis on population-based health outcomes, including on developing a new strategy for community-based services based on teamwork, including the rolling out of community health workers. (167)

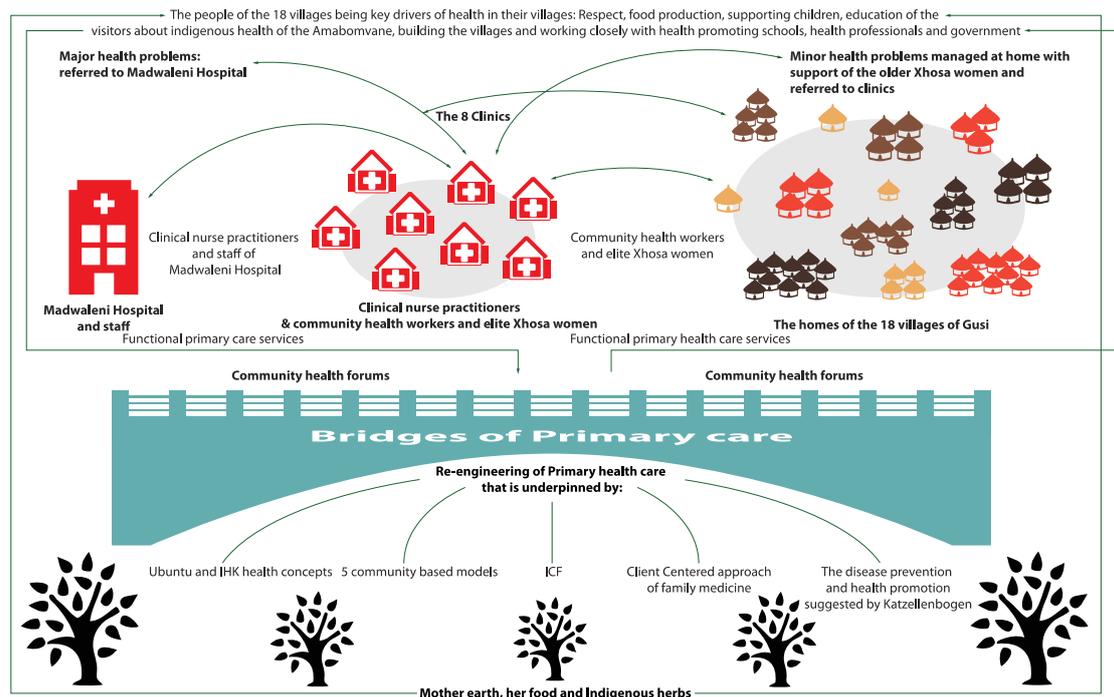
The aforesaid revitalisation of the PHC appears to be giving hope, especially to those in the neglected rural areas (18,19,32), and could be an important development for some of the

challenges that are faced by the older Xhosa women with regard to the management of health problems in their own homes. Caution should, however, be advised to the planners of the PHC revitalisation, as Alma Ata recognised that health improvements are a matter of more than just developing more health services, or of centrally imposed public health solutions. (10,11,13,18) Alma Ata heralded a shift in power from the providers of health services to the consumers of the health services and the wider community. (134) The wider community approach sees the home as the first entry point to the PHC, and the older Xhosa women from the 18 villages of Gusi as first-line practitioners. (3,19) The planning of the revitalisation of PHC needs to be supported with evidence from the study. No work has yet been done that accords the home its rightful place as the first entry point to PHC and which regards the older women as first-line practitioners. (3,19) It is in this regard that the current study suggests the adoption of a rural PHC model to be piloted in the 18 villages of Gusi.

### 6.3.1 The rural primary health care model envisaged for the 18 villages of Gusi

Figure 6.7 below is a representation of the cross-sectional component of the rural primary health model envisaged for the 18 villages of Gusi.

#### A rural primary health care model for the management of health problems in the 18 villages of Gusi



**Figure 6.3: The rural primary health care model for the management of health problems in the 18 villages of Gusi**

#### *A brief description of the functioning of the rural PHC model*

The above-mentioned model envisages the following:

- The people of the 18 villages of Gusi are the key drivers of the model.

- The community health forums serve as a link between the various stakeholders,
- The 18 villages of Gusi are responsible for the management of minor health ailments, social health determinants and the early detection of other health problems.
- The eight clinics supervise minor health ailments and social health determinants, and help with the early detection of other health problems, with proper referrals.
- The hospital provides prompt intervention in the case of other health problems and in the monitoring of the smooth running of the suggested rural PHC model.
- Mother Earth, the sea and two rivers supply the people of Gusi with water, food and herbs, including grazing land for the animals.
- The external agents are the government, academics, researchers and international partners.

### **6.3.2 A presentation of an outline of the functioning of the model**

Steps should be put in place for the management of each category of the health problem.

The model will be implemented in the following steps:

- Step One: Identify the strategies to be used in strengthening and driving the model.
- Step Two: Map out activities to be performed in, and for, the rural PHC model.
- Step Three: Pilot the implementation of the rural PHC model.

#### **6.3.2.1 Step One: Identify the strategies to be used in strengthening and driving the rural primary health care model**

The rural PHC model will utilise, and will be driven by, the six strategies suggested in the literature review of the current study. The following strategies, which are related to community-based resources, will contribute to and drive the rural PHC model for the 18 villages of Gusi:

- Community-based resources: Social capital; the asset model; horizontal learning; the power of relationships; and the interdependence of communities. (111,112,114,115,123)
- Health promotion and disease prevention of Katzellenbogen (82): primordial, primary: minor health problems, immunisation and environmental factors; secondary: early detection and prompt intervention; tertiary: curative approach to disease and rehabilitation.
- The Kleinman's health belief model: the popular, the folk and the professional arena. (36)
- The client-centred approach of family medicine. (169,170)
- The International Classification of Functioning, Disability and Health (ICF). (147)
- The Ottawa Charter of 1986 (15): Advocacy, mediation and enablement.

The majority of the above-mentioned strategies are community-based resources that can be unlocked for utilisation in the rural PHC model. An outline of the contribution that is made by each strategy to the rural clinical model is outlined in Appendix G.

### 6.3.2.2 Step Two: Map out activities to be performed in, and for, the rural primary health care model

The mapping out of activities to be performed in, and for, the rural PHC model will be underpinned and driven by the six strategies identified in 6.3.2.1, which is outlined in Table 6.5.

**Table 6.5: The mapping out of activities to be performed in, and for, the rural primary health care model**

<b>Prevention and health promotion strategies (82)</b>	<b>Available assets</b>	<b>Involved individuals and focus areas</b>	<b>Contribution to the rural PHC model</b>	<b>Outcomes</b>
Primordial: Health promotion: target groups where risks are low. Disease prevention: target groups where risks are high.	The homes of the 18 villages of Gusi; the <i>imbizo</i> ; the health-promoting schools; places of worship and ritual; the land, its vegetation, herbs, rivers and the sea, as well as the animals of the Bomvane (cattle; horses; sheep; goats; fowls; dogs; donkeys; etc.).	Managed and facilitated by the chief. Key role-players: the elite Xhosa women; the councillors; the school principals; the leaders of Amabomvane rituals; the CNP. Target areas: The chiefs' <i>imbizos</i> ; Amabomvane places of ritual and the churches; the schools; the clinics.	Targeting of the social determinants of health already mentioned by the older Xhosa women.	The focus will be on the development of concrete strategies for both the primary and the secondary determinants of health. Village health forums will be developed to support and to monitor the rural PHC model.
Primary prevention: Prophylactic medication, immunisation and the control of environmental disease.	The homes of the 18 villages in Gusi.	Managed by the older Xhosa women, with the support of the elite Xhosa women, community health workers and the CNP.	Targeting mainly of minor health ailments in the home and support of the older Xhosa women, together with identifying the social determinants of health and health problems requiring referral.	Health promotion and disease prevention to eliminate the three categories of health problems within the home situation.
Secondary prevention: Early	The eight clinics.	Managed by the clinic and CNP, with the support of	Targeting mainly of other health	To implement primary care in

detection, the initiation of intervention programmes, strong referrals and public education.		the community health care workers, the elite Xhosa women, the traditional healers, the older Xhosa women, the hospital, and the village health forums.	problems that early detection and prompt intervention require, and that might require referral to other health care providers, and the management of chronic conditions.	the homes and the villages of Gusi, focusing on social health determinants and minor health ailments, and on the early identification of, and referral to, other health providers.
Tertiary prevention: Early intervention; treatment and rehabilitation; and community reintegration.	The hospital.	Doctors, nurses, rehabilitation professionals, CNPs from the clinics, elite older Xhosa women, community health workers and older Xhosa women and their families.	Targeting of conditions that require further investigation and direct hospital intervention.	To gain an overview of how the three categories of health problems are managed within the home situation and the clinics, and in order to strengthen the hospital in managing the other health problems that the older Xhosa women see as requiring referral.
Support and critical appraisal and review	Assistance with support and monitoring, and evaluation of the rural PHC model.	Developed village health committees linked to each clinic, consisting of all stakeholders integrated to the committee in the form of external support, consisting of: <ul style="list-style-type: none"> <li>• the government;</li> <li>• the universities; and</li> <li>• the international partners.</li> </ul>	Linked to each clinic to target the four layers of the model: primordial; primary; secondary; and tertiary levels.	To monitor and evaluate each entity playing its role, in seeing to the success of the implementation of the rural PHC model.

### **6.3.2.3 Step Three: Pilot the implementation of the rural primary health care model**

#### *a) The primordial level of health promotion and disease prevention: The primary and secondary social health determinants*

The target area in this level will be the social determinants of health (both primary and secondary), as was mentioned in Table 6.5 above. In the workshops, the intention is first to validate and to improve the primary and secondary social determinants of health, with the

assistance of all the key stakeholders. The table should be used as a yardstick for evaluating the health status of the 18 villages of Gusi. All members of the 18 villages will be asked for suggestions as to how to turn the negative health determinants that appear to be dominating the health status of Gusi villages into positive outcomes. A timeframe should be proposed by village members as to when to measure where the 18 villages of Gusi are with regard to their health status. It is within this forum that the development of village health forums for the cluster of villages around each clinic should be developed. A similar process can be followed in terms of obtaining a common definition of health for the 18 villages of Gusi.

*b) Primary prevention: minor health ailments*

It is suggested that the first step to be taken regarding the list of health problems emerging from the current study is to work with the CNPs of the eight clinics of Gusi, in order to reach an agreement regarding the minor health problems that could be managed at home. Health professionals from the hospital and the eight clinics should compile a list of health problems that could be managed at home (i.e. minor health problems). It is suggested that the list that has already been compiled of the results obtained by way of the older Xhosa women should first be verified (see Table 6.3, p. 241). The list of minor health ailments identified by McWhinney (68) and Barber (69) could be used to enhance the list of ailments that the older Xhosa feel assured that they can manage at home. Thereafter, a series of workshops could be conducted to delineate where, and by whom, each ailment should be managed.

➤ **First workshop, aimed at determining which minor health problems could be managed at home**

The first workshop should be for hospital staff and for the managers of the eight clinics of Gusi, as well as for the elite Xhosa women from the areas from which the four FGs were drawn, in order to clarify the following issues:

- What are the minor health problems that can be managed at home?
- What are the signs and symptoms of the health problems that can be managed at home?
- When should you take an illness that can be managed at home to a health care facility?

➤ **Second workshop, aimed at determining from the elite women what could be used for managing the minor health problems at home**

Elite older Xhosa women should be asked to describe the various steps that they would take to manage each minor health ailment. They will be asked to submit examples of herbs/medication that they would choose to use for managing the health problem. Samples of the herbs will be taken for pharmacological testing with regard to their safety and suitability for human consumption. This would mainly be the terrain of the older Xhosa women, with the support of the elite older Xhosa women and of the community health workers, with the latter monitoring when a minor health problem becomes a major health problem.

c) *Secondary level of prevention: the other health problems that the older Xhosa women will be required to refer to a health facility outside the home*

The secondary level of prevention will concentrate on the list of critical incidents that have to be referred to a health care provider outside the home.

➤ **Third workshop, aimed at determining the other health problems that the older Xhosa women will be required to refer to a health facility outside the home**

This is a challenging area, as the older women appeared to be confused about what they should do when their management strategies failed to contain the health problem within the home. This area requires decisive action from all role-players with regard to where and how, as well as by whom and when, the health problems should be managed. All of the key stakeholders will be invited to a workshop, at which they will be asked to verify the list, and to add other health problems that the women have not mentioned. The key questions for the workshop should be:

- What are the illnesses that commonly complicate, and which the older Xhosa woman have had to refer to health services outside the home?
- What are the symptoms of the illnesses?
- Is there first help that can be given by the older Xhosa women to those suffering from the illnesses, and, if so, what does it entail?
- When should the older Xhosa women refer the health problem to outside help and support?
- By whom, and where, can the illnesses be managed?

d) *Tertiary level of prevention*

The level will include the hospital managers and key stakeholders validating the information from the workshops regarding the prevention measures taken by the other levels. Included will be the checking of referral systems to the hospital, as well as transport for picking up

people at home and from clinics when they are struggling with health problems that cannot be contained by either the home or the clinic. The fourth workshop will consist of four different phases, as outlined below.

➤ **Fourth workshop, which will be divided into four phases of a series of workshops to be held at the hospital for the Gusi villages**

The aim of the workshop would be to share what has been achieved in the previous workshops and to situate the other health problems that the older Xhosa women experience as critical incidents, which they manage at home, together with the management staff of the hospital and the key stakeholders (i.e. the chief; the councillor; the school principals; the CNPs; the community health workers; and the traditional healers).

*First Phase:* The phase is aimed at providing feedback on the workshops regarding the management of minor health problems. This includes the management strategies adopted towards minor health problems and validates information obtained from the first workshop. In the workshop, such aspects as transparency about what one has used as medication, respect for one another from all parties, and the willingness to learn from one another, will be further endorsed by all parties.

*Second Phase:* The phase, which will follow the format of the first phase, will be aimed at explaining what the health problems are that commonly have complications, and which the older Xhosa woman have had to refer to health services outside the home. The signs and symptoms of these health problems, including where they should be managed, will also be covered.

*Third phase:* The phase is aimed at discussing and clarifying the roles and responsibilities of each category of health provider within the 18 villages of Gusi. Commitment to supporting the primordial stage of the model on health promotion and disease prevention will be secured, and how this can be achieved by each role-player will be clarified.

e) *Support, critical appraisal and review*

1. Conducting of feedback workshops: The researcher will facilitate the feedback workshops for the 4 groups in the 18 villages of Gusi. The aim of the feedback workshops will, firstly, be to validate the list of the three categories of health problems that are managed by the older Xhosa women, and, secondly, to pilot the rural primary health model to the various stakeholders in the 18 villages of Gusi.
2. Other feedback mechanisms will include:
  - attending conferences to disseminate results; and

- developing policy briefs for the different stakeholders who could assist in the implementation of the rural primary health model in the 18 villages of Gusi, as listed below:
    - the National Minister for Health and the Provincial Minister for Health;
    - the matrons, superintendent and hospital manager of the hospital in Gusi;
    - the CNPs at the eight clinics;
    - the Head of Department of Interdisciplinary Health Sciences;
    - the Dean of the Faculty of Health Sciences;
    - the Vice-Chancellor of Stellenbosch University.
3. Lobbying of international partners to invest in the rural PHC model, by sending their own students to the area concerned, and the writing of collaborative research proposals to monitor and evaluate the model after every five years, in terms of which the model will be evaluated as a model of best practice. The above will be linked to Stellenbosch University's Hope Project.

#### **6.4 RECOMMENDATIONS FOR THE KEY STAKEHOLDERS IN THE STUDY**

Recommendations are made to the key stakeholders in the current study with regard to the IHK that is utilised by the older Xhosa women in their home situation.

##### **6.4.1 Recommendations for the study**

The recommendations for the study for the following key stakeholders in the 18 villages of Gusi are outlined below:

- the chief and the people of Gusi;
- the older Xhosa women and their families;
- the CNPs; and
- the matron and the superintendent.

##### **6.4.1.1 *The chief and the people of Gusi***

Once the key findings of the current study have been presented to the chief and to the inhabitants of Gusi, the following recommendations will be made to them:

- a. The chief and the inhabitants of Gusi must take cognisance of what the older Xhosa women have said regarding the maxim that healthy homes make healthy villages. The chief needs to tackle both the primary and secondary social determinants of health. A village health forum is recommended to assist him in devising some solutions as to how to deal with the primary and secondary social determinants of health.

- b. The chief should ensure that the older Xhosa women, who have had, in the past, to care, by themselves, for unruly and vulnerable grandchildren, are supported; this is where the culture of ubuntu should come in, in order to ensure that there is stability in such homes. The village should develop a sustainable solution for supporting the older Xhosa women. Once the older people are supported, they can concentrate on supporting the health of the home.
- c. The chief should work closely with the clinic and the hospital to ensure that the patients with identified diseases are cared for, and that there are clear plans for their management. The starting point would be the knowledges and resources that are available in the 18 villages of Gusi.
- d. Bomvane should also be encouraged to protect and preserve their indigenous knowledges, including their IHK, for future generations. The traditional cultural practices that have a negative impact on the health of the communities should be workshopped, as well as how gradually to relinquish the practices with a backward and forward movement. (14)
- e. An alert awareness of new knowledges, including the health knowledge that has been brought to the 18 Gusi villages, and of the impact of the knowledges on the welfare of the people of Gusi, should be cultivated. (30) Working with outsiders to understand the contribution made by the cultural practices related to being a Bomvane should promote the health of the communities. (12,13, 176, 177) The revitalisation of PHC offers such an opportunity. (160)

#### **6.4.1.2 *The older Xhosa women and their families***

The older Xhosa women are encouraged to focus directly on minor health ailments, and to act more as identifiers, advisors and supporters in the case of the other health problems. It is recommended that the older Xhosa women should:

- a. take pride in maintaining an observant and responsive approach towards the health of their families;
- b. work with the CNPs, the community health workers and the elite Xhosa women in finalising the list of minor health ailments that have been identified in the current study;
- c. describe the herbs and the management strategies for the management of minor health problems to other health providers, including what they have used when their own relatives were ill;
- d. continue to manage minor health problems and to identify promptly other health problems, so that they can, in turn, promptly alert the community health workers and

the elitist Xhosa women once they notice the occurrence of disease amongst their family members;

- e. realise that their knowledge can only be understood when they discuss it with the health professionals; and
- f. see how their health knowledge can be integrated into the social life of the 18 villages of Gusi by means of the health services; *imbizos*; village health forums; schools; indigenous rituals; and churches.

#### **6.4.1.3 The clinical nurse practitioner**

The current researcher recommends the following:

- a. The CNP should join hands with the community health workers and with the elitist Xhosa women in managing minor health ailments that are treated by the older Xhosa women in the home situation.
- b. The CNP should learn about the herbs and strategies that are used by the older Xhosa women for the management of minor health problems within the home situation, and should listen well to the older Xhosa women sharing their experiences as to how they have managed health problems in their home situation.
- c. The CNP should be ready to teach older Xhosa women about the aetiology and presentation of diseases, especially those with which they struggle within the home situation, so that they can also learn about biomedical care. The CNP should encourage the early detection of disease and the need to refer to the clinic any patient with a disease that the older women feel that they cannot manage.
- d. A bridge of caring should be built between the home and the primary health service (i.e. the clinic) for the management of minor health ailments within the home situation, in relation to which the older Xhosa women play a pivotal role. Another bridge of care should be built between the clinic and the hospital for the management of the other health problems that the older Xhosa women experience as critical incidents.
- e. The CNP needs to work closely with the village health forums to address the social health determinants. The underpinning principle would be to revive the sense of pride in being a Bomvane, so that community members will strive to preserve the health of their community in modern times.

#### **6.4.1.4 The hospital and its health care providers**

With regard to the three categories of health problems that have been identified by the older Xhosa women, the current study would like to make recommendations to the following key stakeholders at the hospital:

- the matron;

- the superintendent;
- the CNPs; and
- the hospital managers.

The recommendations are that they should:

- a. attend the workshops that are meant to improve on and validate the lists of the three categories of health problems, and so be part of the development of a rural PHC model;
- b. support and advocate for the rural PHC model to provincial and national health departments;
- c. support and facilitate the piloting of the rural PHC model in the 18 villages of Gusi;
- d. ensure that the hospital has adequate health resources for managing the other health problems that require referral by the older Xhosa women;
- e. facilitate and improve communication and attitudinal issues that are undermining the delivery of comprehensive health care in the 18 villages of Gusi, including the training of interpreters as a short-term goal, and the long-term goal of learning and using isiXhosa by all health professionals; and
- f. focus more on disease prevention and health promotion, in order to assist the Amabomvane people to regain their identity and a good health status.

#### **6.4.2 Recommendations to external agents**

With regard to IHK, the recommendations to the following key stakeholders that could directly assist in the facilitation of its use and retention are given below:

- the National Department of Health;
- Stellenbosch University;
- the South African government; and
- the National Research Foundation (NRF).

##### **6.4.2.1 National Department of Health**

The current study hopes to have a direct impact on policy frameworks for the revitalisation of PHC (160) and the introduction of National Health Insurance (NHI) (167) by giving feedback regarding the findings of the study to the National Department of Health. There is an urgent need to address the following issues:

- a. The description and cataloguing of the various health providers in communities, especially the rural communities. There is a need for a thorough investigation of the status and role of indigenous and traditional health within the national health plan and to obtain clarity regarding how the information will influence, and fit in with, the revitalised PHC and the NHI. (160,167)

- b. The revitalisation of PHC should focus on the strengthening of South African homes as the first institution in which health maintenance and the prevention of disease should occur. Domestic resources used for responding to minor health ailments, in relation to which the older women play a more prominent role in being the first-line managers of minor health problems within the home situation, should be harnessed. (3,19,82)
- c. A framework for rural health model within the home situation in the 18 villages of Gusi has been suggested in this thesis, wherein it is suggested that the National Department of Health should put funds in place to implement, monitor and evaluate the model. If the strategy has a positive outcome, the same approach should be replicated in dealing with the management of health problems within the home situation nationally.
- d. The development of an accreditation system, whereby home-based healers and carers can be accredited.
- e. The facilitation of research with regard to IHK that is utilised by the older Xhosa women and which is seen as an entry point to PHC. (3,7,8,19)

#### **6.4.2.2 Stellenbosch University**

Stellenbosch University unveiled the Hope Project in 2010. The main aim of the Project entails the eradication of endemic poverty and related conditions, and the promotion of human dignity and health. (178) The Vice-Chancellor of Stellenbosch University is the main driver of the Project. The five strategies of the Project resonate closely with the majority of the social determinants of health with which the older Xhosa women are struggling. It is in this regard, then, that the following recommendations are made to SU:

- a. Stellenbosch FMHS should assist with developing small booklets in isiXhosa about the minor health ailments that can be managed at home. The topics of such booklets could include management strategies, and an appendix of ailments that cannot be managed at home, including their signs and referral sources.
- b. The FMHS should introduce a model for training to assist medical students in adopting a culturally-sensitive approach to clients from indigenous communities. (41) While the FMHS of SU is already placing medical students at the hospital in Elliotdale for elective programmes, it is suggested that an integrated team of students should be sent to the area, including students from the rehabilitative and allied health science faculties. The elective could include placement with an elite older Xhosa woman who could assist them in understanding other forms of healing, such as with the IHK carried by the older Xhosa women.

- c. SU's FMHS should develop a partnership with the Pharmacy Department of the University of the Western Cape in order to test the herbs for their effects on minor health ailments. During the process, the issue of the intellectual property of the Mabomvane people would have to be given serious consideration.
- d. SU's Faculty of Theology and Education should also send students to the 18 villages of Gusi to join the above-mentioned interdisciplinary team. The three groups of students (FMHS, Theology and Education) could conduct feasibility studies on the health system operating in the 18 villages of Gusi in relation to health, religion and education, and bring back information to their faculties, with the aim of developing a model in the three areas that will ensure that the people of Gusi are the primary drivers of the development of the knowledges and the model, with Western knowledge being the secondary driver.
- e. A division of Fammed +PC should investigate the incorporation of the IHK model into the current patient-centred care model used to evaluate patients.

#### **6.4.2.3 National Research Foundation (NRF) and Medical Research Council (MRC)**

Both the NRF and the MRC have focus areas in the indigenous knowledges. The current researcher suggests that the two research institutes take Gusi village as a case study and apply the following recommendations:

- They should use the model of health and illness to pilot an action research study to see whether they can reverse the negative social determinants of health that the older Xhosa women have specified. (82)
- The area of functionality that is used by the older Xhosa women offers an exciting area of enquiry for rehabilitative professionals. The area requires exploration with regard to the indicators of the status of functionality in the 18 villages of Gusi.
- The indigenous herbs offer another opportunity for research.
- Lastly, a call is being made for two of the institutions to develop a catalogue of indigenous medicines for all nine provinces, for future generations of South Africans. The medications should undergo rigorous testing for their effects, which might imply the relinquishment of external agents who supply South Africa with medicines. IHK can only gain respect from other health approaches if it is validated for its effect on health problems.

#### **6.4.2.4 The South African government**

The current researcher advocates that the South African government should:

- a. develop the rural areas, with the development template being taken from the people of the village in the form of *a backward and forward movement*. (14) At present, the

South African government is being blamed for the majority of the negative social determinants of health in the 18 villages of Gusi.

- b. ensure that the workforce for the development comes from the rural areas, in order to provide jobs to the villagers.
- c. have a short, intermediate and long-term plan for the integration of indigenous languages into the education system of South Africa.
- d. allow ministries that deal with vulnerable groups, such as women, children, and the disabled and rural people, to be given more resources to ensure that they are effective in their development programmes, with all ministries seeing rural development as a priority, not only for the rural people, but for all South Africans.

## **6.5 CONCLUSION**

Many studies have already challenged the manner in which PHC has been implemented in developing countries, as it has appeared to focus on the curative approach to disease, and has left out prevention and health promotion. It is within this area that the older Xhosa women appear to express the greatest concern for the health of their homes and villages. The problem that was expressed by older people in the community health forums in Khayelitsha in Cape Town, in terms of the broken family units resulting from the migration of young people to the cities, the older Xhosa women in the Eastern Cape appear also to be struggling with. The problem has been brought about by the migration of young adults to the cities seeking jobs. The older people who are left behind struggle to keep the home together, as they lack resources for enabling them to work hard on assisting with the production of food and on building the home and village.

In the initial implementation of the current study, the older Xhosa women resisted speaking only about the disease part of the health problems that they managed within the home. To them, health problems included social determinants of health, as, according to them, each disease was linked to a social determinant of health, and the management of health problems included the management of social determinants of health. To them, it was about the health of the home, and not just about the management of disease. They suggested that healthy homes make healthy villages. For them, the prevention of the development of disease was related to the strengthening of the home. Such thinking is similar to that which was dealt with in the initial PHC strategy that was devised in Alma Ata in 1978.

The older Xhosa women outlined three categories of health problems that appear to be blighting the health of their homes and villages. The social determinants of health were being played out within the homes of the 18 villages of Gusi, and were undermining the

caring role that had been assigned to the older Xhosa women, who ensured that the health of the home was maintained. Neglecting to keep the home healthy by performing certain activities and rituals meant that the older Xhosa women were dealing with a vast number of health problems, of which some were quite new, and they lacked the resources as to how to manage them. To revitalise PHC for health to prevail in the 18 villages of Gusi, a start in, and focus on, the social health determinants of disease is required.

The current study has shown that improved access to health services does not mean the improved health status of the community. Buhrmann explains the importance of not only linking health to an individual but to the whole community, especially in preliterate communities, in which health knowledge is passed on by word of mouth from generations to generation. There is a need to put in place processes for supporting the older Xhosa women, as the present study has shown how vulnerable they are, due to the challenges that they are facing. This will assist in the preservation of the IHK carried by the older Xhosa women.

Now that there a promise of NHI and the revitalisation of primary health, the current study proposes that the two major national health policies should take cognisance of the IHK utilised by the older Xhosa women, and should develop a clear plan as to how the knowledge can be supported within a health care systems approach. A rural health model is proposed by the study as a way of doing this.

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## APPENDICES

### Appendix A: Consent in English

#### PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

##### TITLE OF THE RESEARCH PROJECT

*The health knowledge carried by rural older Xhosa women in the management of health problems in their home situation, with special focus on indigenous health knowledge (IHK)*

**REFERENCE NUMBER:** 2002/CO47

**PRINCIPAL INVESTIGATOR:** MsGUBELA MJI

**ADDRESS:** Centre for Rehabilitation Studies, Health Science Faculty, Stellenbosch University

**CONTACT NUMBER:** 021 938 9528

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the staff conducting the study or the doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

##### **What is this research study all about?**

- This study will be conducted in the Eastern Province rural area (Madwaleni)
- The study aims to explore the IHK carried by the older Xhosa in the management of health problems in their home situation and to raise awareness amongst specific stakeholders regarding this knowledge.

**Why have you been invited to participate?**

- As an older Xhosa women it is assumed by the study that you carry IHK regarding the management of health problems in the home situation and the researcher would appreciate it if you could share this knowledge with her.

**What will your responsibilities be?**

- To share to the best of your ability how health problems could be managed in the home situation
- To respond to the best of your ability to any questions regarding the status of IHK in South Africa and to assist in paving the way showing how this knowledge could be integrated into the present PHC services and education institutions.

**Who will benefit from your taking part in this research?**

- The older Xhosa women who carry IHK;
- Patients who use the services of CHCs;

**Are there in risks involved in your taking part in this research?**

- No risks are involved when you participate in this research.

**Who will have access to information collected in this study?**

- Information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participant will remain anonymous.

**What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?**

- There is no risk of injury involved in participating in this study.

**Will you be paid to take part in this study and are there any costs involved?**

- No, you will not be paid to take part in the study, but your transport and meal costs will be covered for each study visit. There will be no costs for you personally, if you do take part.

**Contact details**

- You can contact Ms Gubela Mji at telephone 021 938 9528 if you have any further queries or encounter any problems.
- You can contact the Committee for Human Research (Stellenbosch University) 021 938 9207 if you have any concerns or complaints that have not been adequately addressed by Ms Mji.
- You will receive a copy of this information and consent form for your own records.

**Declaration by participant**

By signing below, I (name) ..... agree to take part in a research study entitled : The health knowledge carried by rural older Xhosa women in the management of health problems in their home situation, with special focus on indigenous health knowledge (IHK)

I declare that:

- I have read or had someone read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2007.

Signature of participant

Signature of witness

**Declaration by investigator**

I (*name*) .....Gubela Mji..... declare that:

- I explained the information in this document to (*name*) .....
- I encouraged him/her to ask questions and took adequate time to answer these questions.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use a translator.

Signed at (*place*) ..... on (*date*) ..... 2007.

Signature of investigator

Signature of witness

## **Appendix B: Ifomuyemvumelwano (Xhosa consent)**

**ISIHLOKO SOPHANDO:** Uphando ngolwazi lwezempilo olufumaneka koo makhulu bamaXhosa basemaphandleni- malunga nonyango lwezigulo abalusebenzisa emakhayeni abo- oluphando lungxininise kulwazi lemvelo

**INOMBOLO YEPHANDO:** 2002/CO47

**UMPHANDI OYINTLOKO:** MsGUBELA MJI

**IDILESI YAKHE:** Centre for Rehabilitation Studies, Health Science Faculty, Stellenbosch University

**IMFONOMFONO:** 021 938 9528

Uyamenywa ukuba uthathe inxaxheba kule projekthi yophando. Nceda thatha ixesha lokufunda oku kulandelayo okuzakuthi kukunike iinkcukacha zale projekthi. Nceda buza nayiphina indawo ongayiqondiyo, ukuze ucacelwe kakuhle malunga nale projekthi.

Kwakhona kubalulekile ukuba ucacelwe kukuba ukuthatha kwakho inxaxheba kolu phando kungentando yakho ngokupheleleyo, kwaye ukhululekile ukuba ungangavumi, okanye ungarhoxa xa kukho ongakuthandiyo.

Olu phando luvunywe lwaza lwarejistarishwa ziinkqubo ezisesikweni zeKomiti yoPhando Lomtu, kwiYunivesithi yase Stellenbosch, lwaye luzakwenziwa ngokwemigaqo esesikweni yophando olwamkelekileyo kwihlabathi, nakuMzantsi Afrika

**IINJONGO ZOLU PHANDO:** Kukuva ngolwazi lwezempilo koo makhulu bamaXhosa basemaphandleni- malunga nonyango lwezigulo abalusebenzisa emakhayeni abo- oluphando lungxininise kulwazi lemvelo

**INGABA UZA KUZUZA NTONI NGOKUTHATHA INXAXHEBA?**

Ukufunyanwa kolulwazi lwezempilo koo makhulu bamaXhosa basemaphandleni- malunga nonyango lwezigulo abalusebenzisa emakhayeni abo- luyakucedisa icliniki nezibhedlele ezinobunzima bokungcwalelwa ngabantu abanezigulo ezingephi.

**INGABA UZA KUHLAWULWA NGOKUTHATHA INXAXHEBA?**

Hayi akukho ntlawulo, ngaphandle kokuba kukho iindleko ongene kuzo, zona ke uyakubuyekezwa ngazo.

**LUYINTONI UXANDUVA LWAKHO XA UTHATHA INXAXHEBA?**

Kufuneka uzimisele ukuba ufike ngexesha elibekiweyo lokudibana nabanye abathatha inxaxheba, ukuze nithabathe inxaxheba kunye ezingxoxweni.

#### NGUBANI OZA KWAZISWA UKUBA UTHETHE NTONI?

Akuzukupapashwa ukuba ngubani othethe ntoni, kuphela nje ingxelo eya kwenziwa iyakwaziwa njengegxelo yabathathi-nxaxheba. Amagama abathathe inxaxheba aya kuba yimfihlo.

#### UKUBA AWUVUMANGA UKUTHATHA INXAXHEBA AKUKHO SOHLWAYO?

Hayi akukho sohlwayo; unalo ilungelo lokwala, yaye loo nto ayithethi ukuba awuzukuxhamla kwiinkonzo eziyakufumaneka ngenxa yolu phando.

Ngawo nawuphina umbuzo onokuba unawo malunga noluphando, qhagamshelana no Mama u Gubela Mji kule nombolo yocingo: 078 1999 055 (Cell), okanye ku 021 938 9528.

Ngokunye ongakuqondi kakuhle malunga nolu phando, qhagamshelana neKomiti yoPhando Lomntu kwi Yunivesithi yase Stellenbosch kule nombolo: 021 9389090 ngamaxesha omsebenzi.

ISILUMKISO: Xa kuqhutywa ezi ngxoxo zoluphando, iintetho zabantu ziyaku rekhodwa okanye ziyaku teyitshwa, ukuze umphandi akwazi ukuthi sele eyedwa amamele iteyiphu. Ngolo hlobo ke kuya kuba lula kuye ukufumana umxholo weengxoxo.

#### ISIFUNGO SOMTHATHI- NXAXHEBA:

Mna..... ndiyavuma ukuthatha inxaxheba kuphando olunesihloko esithi: Uphando ngolwazilwezempilo koo makhulu bamaXhosa basemaphandleni- malunga nonyango lwezigulo abalusebenzisa emakhayeni abo- oluphando lungxininise kulwazi lemvelo

Ndazisa nokuba:

Ndiyifundile ifomu yemvumelwano, kwaye ibhalwe ngolwimi endilwazi kakuhle nendikhululekileyo kulo.

Bendinalo ithuba lokubuza imibuzo, kwaye yonke imibuzo yam iphendulwe ngokwanelisayo.

Ndiyaqonda ukuba ukuthatha inxaxheba kolu phando kube kukuzithandela kwam, kwaye andikxange ndinyanzelwe ukuba ndithathe inxaxheba.

Ndiyaqonda ukuba xa kukho endingakholwayo kuko ndingayeka naninina kolu phando, kwaye andisayi kohlwaywa nangayiphina indlela.

Kusayinwe e-(indawo).....nge.....20

.....

Umtyikityo womthathi-nxaxheba

Umtyikityo wengqina

ISIFUNGO SOMPHANDI:

Mna Gubela Mji, ndiyafunga ukuba:

Ndilucacisile ulwazi olukule fomu ku .....

Ndimkhuthazile ukuba abuze imibuzo, kwaye athathe ixesha lakhe elifanelekileyo; ade aziqonde iimpendulo zemibuzo yakhe.

Ndiyaneliseka kukuba uyakuqonda konke okumalunga nolu phando aza kuthatha inxaxheba kulo.

Andisebenzisanga toliki, kuba bonke abazakuthatha inxaxheba bathetha isiXhosa.

Kusayinwe e-(indawo).....nge.....20

.....

Utyikityo Lomphandi

Utyikityo Lwengqina

UMYALEZO KUMTHATHI NXAXHEBA:

Mthathi-nxaxheba obekekileyo, ndigqithisa ilizwi lommbulelo ongazenzisiyo kuwe, ngokuba uthe wavuma ukuthatha inxaxheba kolu phando. Ndinethemba ke lokuba kukhona okuya kuba yinzuzo kuwe ngenxa yalo.

Ukuba kusekho omnye umbuzo onawo, okanye enye into oyikhumbuleyo ongakhange uyithethe, nceda undifonele kule nombolo yefoni: 078 1999 055

Enkosi

Owenu Ozithobileyo

G. Mji

## Appendix C: Interviewing guides

### INTERVIEWING GUIDES

FG interviewing schedules for the older Xhosa from the rural Eastern Cape were based on the primary objectives of the study. There were mainly three data sources for this study.

*The data sources for this study were:*

- FGDs with older Xhosa women from each of the four villages.
- Sixteen older women regarded as the elite in IHK.
- Family members of the elite older Xhosa woman.

Below are the interviewing guides for these data sources:

#### **(a) Focus group discussions with older Xhosa women from each of the four villages.**

The older women were asked to describe the following:

- Explain their understanding of health and illness/illness;
- the health problems that older Xhosa women manage at home;
- the steps that older Xhosa women take to come to a conclusion that the person is having a specific health problem;
- the steps and management strategies that older Xhosa women use at home for health problems;
- the home remedies that older Xhosa women use for the management of these health problems;
- whether different types of health problems (such as the critical health-related incidents) influenced the decision-making of older Xhosa women;
- the rationale that would lead to older Xhosa women relinquishing health management strategies at home and refer the person to an outside source;
- the referral source that older Xhosa women use to further manage the illness and the rationale for that choice; and
- the opinion of the older Xhosa women regarding how their knowledge could be integrated in the present health dispensation, including the contribution it could make.

**(b) Sixteen older women regarded as the elite in IHK.**

The older women that were regarded as elite older Xhosa women were asked:

Why were they consulted by the older Xhosa women when somebody was ill and the older Xhosa women could not manage the illness at home and to also name critical incidents related to illnesses that were referred to them by the older Xhosa women.

**(c) Family members of older Xhosa woman in from each of the four villages.**

Family members of the older Xhosa women were asked:

Who is consulted in their homes when a family member is ill and why?

**Appendix D: Zonke's list of health problems managed at home by older Xhosa women****Table 1: List of minor health ailments mentioned by older people in each focus group.**

<b>Noxolo</b>	<b>Masiphumelele</b>	<b>Mzamomhle</b>	<b>Masithandane</b>
<b>Focus group 1</b>	<b>Focus group 2</b>	<b>Focus group 3</b>	<b>Focus group 4</b>
1. <i>Ithumba</i> Boil	1. <i>Ihlaba</i> Chest pain	1. <i>Ithumba</i> Abscess	1. <i>Ithumba</i> Abscess
2. <i>Ihlaba</i> Chest pain	2. <i>Ukubelekisa</i> Child delivery	2. <i>Ukhothelwa ngumlambo</i> Allergy	2. <i>Isifuba esibuhlungu</i> Chest pain
3. <i>Ukubeleka</i> Child delivery	3. <i>Ukuqhineka</i> Constipation	3. <i>Umqolo obuhlungu</i> Backache	3. <i>Ukhohlokhohlo</i> Coughing
4. <i>Ukhohlokhohlo</i> Coughing	4. <i>Ukhohlokhohlo</i> Coughing	4. <i>Ukutsha</i> Burns	4. <i>Ihlaba</i> Chest pain
6. 5. <i>Indlebe ebuhlungu</i> Earache	5. <i>Indlebe evuzayo</i> Ear discharge	5. <i>Ihlaba</i> Chest pain	5. <i>Ukubelekisa</i> Child delivery
6. <i>Ubushushu</i> Elevated Temperature	6. <i>Ubushushu</i> Elevated temperature	6. <i>Ukhohlokhohlo</i> Coughing	6. <i>Indlebe ebuhlungu</i> Ear ache
7. 7. <i>Umoya omdaka</i> Evil spirit	7. <i>Ukuxhuzula</i> Epilepsy	7. <i>Lindlebe ezibuhlungu</i> Ear ache	7. <i>Ukuxhuzula</i> Epilepsy
8. 8. <i>Intloko ebuhlungu</i> Headache	8. <i>Inyongo</i> Excessive bile	9. 8. <i>Ubushushu bomntwana</i> Elevated temperature	8. <i>Imvuma/Amehlo</i> Eye infection
9. <i>Umiselo</i> Infertility	9. <i>Amehlo/imvuma</i> Eye infection	9. <i>Amehlo abuhlungu</i> Eye-ache	9. <i>Isifesane /Ildo</i> Finger abscess
10. <i>Isinqe</i> Low back pain	10. <i>Umgqwaliso</i> Face allergy	10. <i>Ukophuka</i> Fracture	10. <i>Intloko ebuhlungu</i> Headache
11. <i>Isiluma</i> Menstruation pains	11. <i>Ukophuka</i> Fracture	11. <i>Intloko ebuhlungu</i> Headache	11. <i>Irhashalala</i> Measles
12. <i>Uqwilikane</i> Mumps	12. <i>Intloko ebuhlungu</i> Headache	12. <i>Iduma</i> Head haematoma	12. <i>Isiluma</i> Menstruation pains
13. <i>Ishimnca</i> Newborn rash	13. <i>Imasisi</i> Measles	13. <i>Isinqe esibuhlungu</i> Low back pain	13. <i>Uqwilikane</i> Mumps
14. <i>Ukudumba</i> Oedema	14. <i>Inkaba</i> Navel extension	14. <i>Imbilaphu</i> Lymph node swelling	14. <i>Ukudumba</i> Oedema
15. <i>Ingxuluba</i> Post-delivery pains	15. <i>Ishimnca</i> Rash of new-born	15. <i>Imasisi</i> Measles	10. 15. <i>Umqala obuhlungu</i> Sore throat
16. <i>i-Drop</i> Sexually transmitted	16. <i>Uqwilikane</i> Mumps	16. <i>Uqwilikana</i> Mumps	16. <i>Isifuba esivalekileyo</i> Tight chest

diseases (male)			
17. <i>Umqala obuhlungu</i> Sore throat	17. <i>Ukukhulelwa</i> Pregnancy	17. <i>Ukumongoza</i> Nose bleed	17. <i>Unkonkonko</i> Tuberculosis
18. <i>Isisu esilumayo</i> Stomach-ache	18. <i>Isisu esihambisayo</i> Runny stomach	18. I-drop Sexually transmitted diseases (male)	18. <i>Izilonda</i> Wounds
19. <i>Igcushuwa</i> Syphilis	19. <i>Amafufunyana</i> Schizophrenia	19. <i>Iinyawo eziqaqambayo</i> Sore feet	
20. <i>Izinyo elibuhlungu</i> Toothache	20. <i>Umqala obuhlungu</i> Sore throat	20. <i>Ukukruneka</i> Sprain	
21. <i>Izilonda</i> Wounds	21. <i>Isisu esilumayo</i> Stomach-ache	21. <i>Isisu</i> Stomach-ache	
	11. 22. <i>Ukugongqok a kwefokotho</i> Suppressed fontanel	22. <i>Igcushuwa</i> Syphilis	
	23. <i>Igcushuwa</i> Syphilis	12. 23. <i>Izinyo eliqaqambayo</i> Toothache	
	24. <i>Unkonkonko</i> Tuberculosis		

**Table 2: Ten Home remedies that were used by older people of Noxolo and the method of administration of those remedies**

Minor ailment	Home-based medicine	Method of administration
1. <i>Ukhohlokhohlo</i> (Colds and influenza)	13. <i>Mhlonyane</i> ( <i>Artemisia Afra</i> )	14. Boil it with hot water, cool it then drink an amount of tablespoon morning and evening
	15. <i>Qwili</i>	16. Boil it with hot water, cool it, and drink one spoon 3 times a day.
	17. ( <i>Alepidea Amatymbica</i> )	18. Then drink one spoon 3 times a day.
	19. <i>Buvumba</i> ( <i>Withania Somnifera</i> )	20. Crush it into cold water, and then let it be strong. Drink 1 spoon 3 times a day.
	21. <i>Gangashane</i>	22. Mix it in cold water overnight, then purge with it in the morning.
2. <i>Ithumba</i> (Boil)	23. <i>Tolofiya</i> (Prickly pear)	24. Warm it first, then put some sugar on the lump and then put it on the lump.
	25. <i>Mhlabawuvuthwa</i> ( <i>Datura Stramonium</i> )	26. Warm the leaves put it on the lump till it burst.
	27. <i>i-Swekile ne-Sephaeluhlaza</i> (Sugar and Sunlight soap)	28. Mix the two, then warm these, then put these on the affected area.
3. <i>Uqwilikana</i> (Mumps)	29. <i>Akukhochizalisetyenziswayo</i> (No medicine required)	30. Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle's". Then return home.
4. <i>Isisu esibuhlungu</i> (Stomach-aches)	31. <i>Ngcelwane</i>	32. Put it in cold water, let it be strong, and then drink 2 spoon of the solution.
	33. <i>Qwili</i> ( <i>Alepidea Amatymbica</i> )	34. Take a piece, chew it, and then swallow the saliva.
	35. <i>Mnonono</i>	36. Crush the leaves into cold water, let it be strong, the drink 1 spoon 3 times a day.
	37. <i>Sipha</i>	38. Crush it into powder form, and then swallow it.
	39. <i>Ntlungunyeba</i>	40. Crush the leaves, and then put it on the nose for the person to sneeze.

4. <i>Intloko ebuhlungu</i> (Headaches)	<i>Irhonya</i> (An old rag)	Burn it; inhale smoke from it.
	41. <i>Iqhiyaemnyama</i> (Black fabric material)	42. Burn it; inhale smoke from it.
	43. <i>Mhlabawuvuthwa</i> ( <i>Datura Stramonium</i> )	44. Put leaves on the head, and then tighten your head with cloth.
5. <i>Ukudumba</i> (Oedema)	45. <i>Jongilanga</i>	46. Warm leaves in warm water, then sooth the affected area.
	47. <i>Sidikidiki</i>	48. Tie leaves on the affected area for a certain period, and then take off.
	49. <i>Mhlabawuvuthwa</i> ( <i>Datura Stramonium</i> )	50. Put the leaves in warm water, then sooth the affected area.
6. <i>Izinyo eliqaqambayo</i> (Toothaches)	51. <i>Mthuma</i> (Bitter apple)	52. Open the fruit, and then pour the inside liquid on the aching tooth.
	53. <i>Jongilanga</i>	54. Boil the roots, crush it into powder form, then put it on the affected tooth.
7. <i>Umkhondo</i> (Evil spirits)	55. <i>Tswelane</i> (Wild onion)	56. Take bulb of it, crush them, boil it with water, cool it, then take 1 spoon 3 times a day.
	57. <i>Konofile</i> ( <i>Ruta Graveolens</i> ) & <i>Vendreti</i>	58. Mix both of these, crush them, put the mixture in cold water then let it be strong, drink it, 1 spoon 3 times a day.
	59. <i>Isicakathi</i> ( <i>Agapanthus Africanus</i> )	60. Put the leaves in cold water, let it strengthen, and then drink it, 1 spoon 3 times a day.
8. <i>Ubushushu</i> High temperature	61. <i>Tswelane</i> (Wild onion)	62. Put the bulb in cold water, and then syringe a child by using horn (anally).
9. <i>Ishimnca</i> (Rash of newborn rash)	63. <i>U-Mthombothi I-Sikrweqa</i>	64. Take a bark, rub against an object and put some water, then smear it on the affected area, take the other and drink it.
	65. <i>Umcham'emfene</i>	66. Let the child drink the mixture of dasiepis.
10. <i>Umqala obuhlungu</i> (Sore throat)	67. <i>U-Nozinxetyana</i> ( <i>Aster Bakerranus</i> )	68. Soak the leaves in water, gaggle with that mixture in the morning and evening.
	69. <i>Iingqathazehagu</i> (Pig's faeces)	70. Put pig droppings in water, then gargle with it morning and evening.

11. Igcushuwa (Syphilis)	U-Sibabile Isephaeluhlaza (Sunlight soap) Ingcelwane	Wash the affected area daily using any of these items i.e. Sibabile, sunlight or ingcelwane.
12. Ingxuluba (Menstruation pains)	71. Idololenkonyane	72. Boil the leaves in hot water, cool it, and then drink it, ½ cup 2 times a day.
13. i-drop (Male STD)	73. U-Jongilanga No- bisi (milk)	74. Mix both and let the ill person drink it, half cup in the morning.
14. Ukubeleka (Child delivery)	75. Umgcantsi (Horse's post-delivery residues) Iintangazethanga (Pumpkin's seeds)	76. Soak the horse's post-delivery residues in water, drink it or soak the pumpkin's seeds in water, then drink it. Measurement is half a cup for both solutions in the morning.
15. Izilonda (Wounds)	77. U-Sibabile Itelaendala (Used car oil)	78. Soak the leaves of the sibabile in water then smear it on the wound. Smear used oil on the wound.
16. Umiselo (Infertility)	79. Amaqandakanonkala (Crab's eggs) Iimbaza (Mussels) Unokrwece	80. Both male and female need to eat all these items as raw as they are. After that they will be fertile and ready to make a child.
17. Imasisi (Measles)	81. Iingqathazebhokwe (Goat droppings)	82. Mix the item with water, drink it half a cup three times a day and some of it smear it on the body.

**Table 3: Home remedies that were used by older people of Masiphumelele and method of administration of those remedies.**

Minor ailment	Home-based medicine	Method of application
1. Ukhohlokhohlo (Coughing)	Iqwili (Alepidea Amatymbica)	Boil the roots in hot water and put some salt on it. Cool it, and drink half a cup morning and evening.
	Umhlonyane ( <b>AertemisiaAfra</b> )	Take its leaves, put it in hot water, soak it, and later drink it half a cup morning and evening.
	I-gamtriya (Gum tree)	Mix the leaves of Gum tree with Aertemisia Afra solution; drink it half a cup morning and evening.
2. Imasisi (Measles)	Iingqatha zebhokwe (Goat droppings)	Mix the item with water, drink it then smear some on the body.
	Umhlonyane ( <b>AertemisiaAfra</b> )	Take leaves, mix it with goat dropping solution, drink it and smear some on the body.
	Ubisi lwebhokwe (Goat's milk)	Drink a cup of milk directly from the goat, and then put the ill in dark place.

3. Igcushuwa (Syphilis)	Inkamasana	Boil the leaves in hot water, cool it, and later wash with it.
4. Isisu esilumayo (Stomach- ache)	Uthuvane	Mix the leaves with warm water, drink it and purge with it out.
	Ikhala (Cape Aloe)	Cut the leaves, soak it water, and drink a spoonful of the solution.
	Itshongwe (Bitter wortel)	Dry the bark, crush it, put half spoon and mix it with water, drink a spoon. Or take a piece of the bark, chew it and swallow saliva.
5. Isisu esihambisayo (Diarrhoea)	Umabophe (Plumbago)	Crush the leaves, put it in luke warm water, and drink half a cup twice a day.
	Umnga (Sweet thorn)	Soak the bark in water and later drink the cup when necessary.
	Utswelane (Wild onion)	Boil the bulb, cool it and drink a spoon twice a day.
	Ipesika (Peach leaves)	Crush the leaves, soak it in cold water, and later drink half a cup three times a day.
	Ujwabisile	Choose the red one, cook the bark, and cool it and later drink half a cup morning and evening.
6. Umqala obuhlungu (Sore throat)	uNomacumcumana	Boil the fruit in hot water; cool it, and gaggle with it morning and evening.
	iGangashane	Crush leaves, boil it, and cool it and later gaggle with it.
	iGcukunya	Chew the leaves and swallow the saliva.
	iTswele lomlambo (River onion) iPepile (Pepper)	Make solution of any of these two herbs and gaggle with it morning and evening.
7. Intloko ebuhlungu (Headache)	Itshongwe	Crush the dry leaves into powder form, put it on nose and sneeze it out.
	Irhonya lengxowa (Old sack rag)	Burn it, inhale its smoke and rest
	uMbezo	Crush the dry leaves, burn it, smoke it and rest.
	Ulwathile	Crush the dry leaves into powder form, put it on nose and sneeze it out.
	Uthuvane	Crush the leaves, pour it on hot water and drink it. It regulates bile which sometimes is a causal factor.
	Ikhama	Crush the bark into powder form, put little water in it and put it on the nose.
8. Inkaba (Navel extension)	uSkhiki (Creeping sage)	Cook the leaves in hot water, cool it and smear the solution on the navel.
	udaka lukanonkala (Crab's mud)	Smear this mud on the navel.
	Uthuthu Iwenqawa (Tobacco's ash)	Mix the ash with mother's milk and smear it on the navel.

	lingqatha zempuku (Mouse's droppings)	Mix the droppings with old wooden ash and mother's milk and put it on the navel.
9. Ubushushu (Elevated temperature)	iGamtriya (Gum tree) Pepatri (Pepper tree)	Take leaves of both Gum tree and Peppertree and rap it around the child.
	uSkhiki (Creeping sage)	Cook the leaves, cool it and syringe it
	Ithongazana	Make a solution with the bark and let the child drink it.
10. Ukubelekisa (Child delivery)	Umle (Smoke residue)	A solution is made out of it, drink it and later blow an empty bottle.
	uSkhiki	Burn the leaves, let her inhale the smoke, it ease anxiety.
11. Ihlaba (Chestpain)	Umkhwenkwe Imfingwana	Grate the barks of both of these and make a concoction and let her drink half a cup when necessary.
	litsiba zencanda (Porcupine's feather)	Just prick the affected are with the feather.
12. Ukuqhineka (Constipation)	lingcambu zenkuzana	Make a solution with the roots, and then let the child drink it.
	uSkhiki (Creeping sage) nesepha eluhlaza (Sunlight)	Mix the leaves of creeping sage with sunlight, insert it on the anus
13. lindlebe ezibhobhozayo (Ear discharge)	uSkhiki (Creeping sage)	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	iKonofile	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	uJongilanga	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	Inyongo yehagu (Pig's bile)	Just pour few drops on the ear
	umchamo wokuqala (Morning's first urine)	Just pour few drops on the ear
	Amagqabi epesika (Peach leaves)	Put the leaves in warm water, and pour few drops on ears.
14. Amehlo / imvume (Eye infection)	Ubisi lwebele (Mother's milk)	Put some drops on the eye
15. Unkonkonko (Tuberculosis)	Isitixo esidala (Old key) Ipeni endala (old coin)	Make a necklace with any of these and let the ill wear it around neck.
	Ubisi lwedonki (Donkey's milk)	Drink the donkey milk half a cup morning and evening.

	Unonkala (Crab)	Cook the crab, let the ill person drink its gravy
16. Ishimnca (Newborn rash)	uMthombothi	Rub any of these two herbs on a flat stone and mix with water and smear on face.
	Umchamo wemfene	
	Ubulongwe bencamazana	Mix it with mother's milk and smear it on the face.
17. Ukophuka (Fracture)	Umhlabelo omhlophe	Crush the bark I powder form, make a solution and drink it.
	Umathunga	Soak it in warm water, and cleanse the affected area.
	Umnga	Tie the bark around the affected area and put two planks around the fracture.
18. Umgqwaliso (Face allergy)	Uvuthuza llabatheka	Put the leaves of any of these two into warm water and steam with it.
	Ufudo Isiqodi Inqwebeba	Make a solution of all the three items, drink it, wash with it, steam with it and purge with it.
	Imbosiso	Put the leaves in warm water, steam and purge with it.
	Inywibiba (Arum lily)	Make a solution with the flower, purge with it, steam with it and wash with it.
19. Ukuxhuzula (Epilepsy)	Umvumvu Mgqomagqoma	Make a solution with leaves and let the ill drink a cup twice a day.
	Inqwebeba neRabiya	Dry the leaves, put it on nose and sneeze it out.
20. Inyongo (Excessive bile)	Umnquma (Wild Olive)	Take leaves, soak in warm water and purge with it.
	Inkuphulana	Take leaves, soak in warm water and purge with it.
	Uthuvane	Take leaves, soak in warm water and purge with it.
	uGobeleliweni	Crush the stem and roots, make a solution and drink it.
	uMsenge	Crush leaves, boil it, cool it, and later drink it
21. Ukugongqoka kwefokotho (Suppressed fontanel)	Isivimbampunzi Ikonofile	Crush the bulb and later make solution, pour it on all openings i.e. nose and anus.
22. Uqwilikana (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle". Then the person would go back home

**Table 4: Home remedies that were used by older people of Mzamomhle and method of administration of those remedies.**

Minor ailment	Home-based medicine	Method of application
1. <i>Isisu esibuhlungu</i> (Stomach-ache)	83. <i>Ikhala</i> (Cape aloe)	84. Crush it, put it in water and drink it.
	85. <i>Ulwathile</i>	Dry it, crush it and inhale till you sneeze.
2. <i>Intloko eqaqambayo</i> (Headache)	86. <i>Irhonya elidala</i> <i>lqhiya emnyama</i>	Take any of these, burn it and inhale the smoke.
	87. <i>Itshongwe</i> (Bitter wortel)	Dig it, dry it, and crush it into powder form and sneeze with it.
	88. <i>Ulwathile</i>	Crush it, soak in water, and pour it on the nose.
3. <i>Ubushushu bomntwana</i> (Elevated temperature)	89. <i>Isivimbampunzi</i> <i>Ikonofile</i>	Take any of these, put the leaves in warm water, syringe it at the back or wash the child with it.
4. <i>Ukhohlokhohlo</i> (Coughing)	90. <i>Umhlonyane</i> ( <i>AertemisiaAfra</i> )  Iqwili ( <i>Alepidea</i> <i>Amatymbica</i> ) <i>negamtriya</i> (Gumtree)	Make a mixture of any of these, drink it or just chew gum tree leaves and swallow saliva.
91. 5. <i>Ukukhothelwa</i> <i>ngumntwana</i> (Allergy)	92. <i>Umsola</i>	Crush it and make mixture with water, drink it and smear some left.
	93. <i>Ingubo yesele</i> (Algae)	Smear it on the face.
6. <i>Indlebe ebuhlungu</i> (Ear ache)	Inyongo yehagu (Pig's bile)	Pour it on the sore ear/s
	Usikhotha	Crush leaves, put on fabric, soak in water and pour drops on ear/s
7. <i>Amehlo abuhlungu</i> (Eye ache)	Ubuthuvi benyanga	Crush the roots into powder form; put it inside the affected eye.
8. <i>Inyawo eziqaqambayo</i> (Sore feet)	Uqaqaqa (Weeds)	Take it with roots, soak it in water and put both feet. Let the feet dry up.
9. <i>Ukophuka</i> (Fracture)	Umnga (Sweet thorn)	Tie the bark around the affected area.
	Umathunga	Soak the leaves in warm water, and cleanse the affected area. Drink some of it.
10. <i>Igcushuwa</i> (Syphilis) 11. <i>i-drop</i> (Male STD)	Unknown	One participant remembered that syphilis was managed but did not remember the herb. Other did not know.
	Umthuma (Bitter apple)	Cut the fruit, soak it in warm water and syringe at anus.
12. <i>Umqolo obuhlungu</i> (Back ache)	Umthuma (Bitter apple)	Cut it, soak it in warm water and syringe it on the buttocks

	Umkwenkwe Uchithibhunga	Make a solution of these two plants (leaves) in water and drink half a cup twice a day
13. Isinqe esibuhlungu (Low back pain)	Umthuma (Bitter apple)	Cut the fruit, soak it in warm water and syringe it on the anus
14. Ithumba (Boil)	Umhlabawuvuthwa (Datura Stramonium)	Put the leaves on warm subject, when warm put it on affected area.
	Iswekile (Sugar)	Put bit water on the sugar and put it on the affected area.
15. Imasisi (Measles)	lingqatha zebhokwe (Goat's droppings)	Mix the item with water, drink it then smear some on the body.
	Ituwa yenkukhu (Chicken droppings)	Make solution with water, drink it and smear some of it on the body.
16. Ukukruneka (Muscle sprain)	Umhlabawuvuthwa (Datura Stramonium)	Tie the leaves on the affected area.
17. Ukutsha (Burns)	Amanzi (Water)	Soak the burnt area in cold water.
	Umthubi weqanda (Egg yoke)	Put egg yoke on the affected area
	Umnga (Sweet thorn)	Burn the bark, take its charcoal and smear it on the affected area.
18. Iduma (Head haematoma)	Igangashana	Dry the leaves, crush it and put it on affected area.
19. Ihlaba (Chest pain)	Umwelela	Chew the leaves and later the pain will vanish.
	Inaliti (Needle)	Pinch the affected area, later it will be better.
20. Imbilaphu (Abscess)	Ikhala (Aloe)	Cut the leaf, warm it and tie it around the abscess.
21. Uqwilikana (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle". Then go back home
22. Izinyo elibuhlungu (Tooth ache)	Umthathi	Burn the leaves, let smoke pass the sore teeth, worm that cause soreness will come out.
23. Ukumongoza (Nose bleed)	Amanzi abandayo (Cold water)	Soak cloth in cold water and put it on the forehead.

**Table 5: Home remedies that were used by older people of Masithandane and method of administration of those remedies.**

Minor ailment	Home-based medicine	Method of application
1. Intloko eqaqambayo (Headache)	Iqhiya emnyama (Black fabric) Irhonya (Rag)	Take any of these, burn it and inhale the smoke.
	Itshongwe	Dig it, dry it, crush it into powder form and sneeze with it.
2. Ukhohlokhohlo (Coughing)	Iqwili (Alepidea Amatymbica) Umhlonyane <b>(AertemisiaAfra)</b>	Boil it hot water and put some salt on it. Cool it, and drink it
	Ubushwa	Take its leaves, put it in hot water, soak it, and later drink it.
	Igamtriya (Gum tree)	Mix the leaves it with Aertemisia Afra solution, then drink it.
3. Indlebe ezibuhlungu (Ear ache)	Iphewula	Cut it, squeeze liquid out, pour it on the ear/s.
	Amafutha enja 'selwandle (Seal's oil)	Pour drops on the affected ear/s.
	Amafutha enkukhu (Chicken's Oil)	Pour drops on the affected ear/s.
4. Umqala obuhlungu (Sore throat)	Igangashane	Make solution and gargle with it.
	Uzifozonke (Potassium permanganate)	Make solution and gargle with it.
5. Isifuba esibuhlungu (Chest pain)	Isivimbampunzi (Garlic)	Make solution using it bulb, cook it, cool it and later drink it.
6. Isifuba Esivalekileyo (Tight chest)	Umhlonyane <b>(AertemisiaAfra)</b>	Make solution, cook it, cool it and drink it.
	Amafutha enja 'selwandle	Drink this one as raw as it is.
7. Ilido/Isifesane (Finger abscess)	Igangashane	Warm the leaves put it on the affected area.
	Iswekile nesepha eluhlaza (Sugar and Sunlight soap)	Mix the two stems and put these on the affected area.
8. Irhashalala (Measles)	Iingqatha zebhokwe	Mix the goat droppings with water, drink it then smear some on the body.
9. Ithumba (Boil)	Ivumbango	Cut the leaf, warm it and put it on the affected area.
	Ikhala (Cape aloe)	Cut the leaf, warm it and put it on the affected area. Tie it with cloth.
10. Uqwilikane (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle's". Then go back home
11. Unkonkonko (Tuberculosis)	Ubisi lwedonki/hashe (Donkey/Horse' milk)	Drink a spoon of any of these, three times a day.

12. Ukudumba (Oedema)	Umhlabangulo	Boil it in hot water, cleanse the affected area.
	Iphewula	Cut it, tie it on the affected area
	Umhlonyane (Aertemisia Afra) nobushwa	Make a solution, drink it.
13. Ukuxhuzula (Epilepsy)	Ilaphu elidala (Old rag)	Burn it, let him/her inhale smoke.
	Uthuvane	Make solution-using leaves, let the client drink it.
14. Izilonda (Wounds)	Amafutha ehagu (Pig's fat) Usibabile	Mix the Pig's fat with the leaves of the Sibabile, and then smear on the wound
15. Imvuma (Eye infection)	Ubisi lwebele (Mother's milk)	Pour drops of mother's milk on the eyes.
16. Ihlaba (Chest pain)	Uzifozonke (Potasium pemananganete)	Make solution, and then drink it.
	Umchamo wemfene	Crush it, make solution, and then drink it.
17. Ukubeleka (Child delivery)	Umchamo wemfene	Make a solution then drink it. It soothes the pain. Sleep on one side and the midwife will do the rest.
18. Isisu esilumayo (Stomach ache)	Ukrakrayo Uzifozonke (Potasium pemananganete)	Make solution of any of the two, drink it
	Itshongwe	Cook the leaves in hot water, cool it and later drink it.

## Appendix E: Outcome of interaction with key stakeholders during community entry and pilot study

### 1. Community entry

#### Discussion with the Chief and the Chieftain: The status of the villages regarding health issues: emerging themes

##### (a) The chief is the carrier of knowledge related to the amabomvane people and their traditions:

This place is the place of the Mbovane tribe. We are people of traditions and rituals. Cattles are something important to our people. In 1740 Qayiya disappeared and came back via the Wild coast with two cows. These cows were our ancestors. They brought prosperity to the Xhosa people. We have lost all these traditions and the appearance of Qayiya with cows was only celebrated once. Qayiya died here in Guse. Our traditions were developed for our culture and wisdom. Each house hold must choose between religion and traditions. A house-holds that practice none that house hold is in great danger (*kuphandle kuwo*). That house hold is in a very poor shape. Do you see this cut finger - He shows me his cut little right finger. The dark forces like blood. To appease them my parents had to let blood flow from me and hence I was protected from them. A person that doesn't pray must do rituals. Health issues are very difficult. When Adam and Eve were chased from the Garden of Eden that is when illness started. God comes through the father of the family. Black people when doing rituals speak to ancestors. They do not speak to God. ***Church happens from inside the kraal/parameter of your house hold, the kraal is where you keep your cattle and this is your religion.***

##### (b) Respectful to visitors, strangers and the chief

I have gratitude from the bottom of my heart that you have come to our villages to seek for this knowledge. Umhlekaazi kudala ethetha (the Chief has been talking for a long time; I must give him rest and take over). I am going to open up, you will select what is necessary in what I am going to say (he then took off his hat). I asked him why his taking off his hat. I am the child of Tipheni; I took off my hat when I am speaking to respectable people. A Chief is the link between God and his people. God look after the Kings and Chiefs. Aah Vuyisile, what will save your religion? God will save a few, so that men do not get destroyed.

##### (c) Knowledgeable about rituals and traditions of Amabomvane

For a newly married woman to the household there were traditions. For example she needs to have a ritual for *ukutyiswa amasi* so that she can be able to enter the kraal to pick up cows dug to clean the rooms. There is a goat for being able to fetch water from the river. Celebrations for a newly married woman when she has finished a specific period so that her

head scarf no longer cover part of her eyes. They would also make Xhosa beer for this celebration. A sheep would be slaughtered too to give her a right to receive visitors of the household. The women after birth would be sheltered for 8 days, then on the 8<sup>th</sup> day there will be a celebration for the new born where by the new born would be swung over open fire with the person holding the baby saying *huntsu uzukhanye* into *oyaziyo* (*hutshu* you must not expose everything you must say you do not know even if you know something). When there is a ritual and a need to celebrate or appease the ancestor. So to appease the devil slaughtering of a cow and rituals must happen - to unite with the evil spirit to appease them.

**(d) The process of child birth is an important one**

When a child is born there is *imbeleko* celebration is made. A child was born here at home. While the women was giving birth the man would be in *kraal* waiting (I also see this waiting in hospital corridors, maybe the home was seen as a hospital those days) and once the child is born, one of the women assisting with the birth would bring the news. The women after birth would be sheltered for 8 days.

**(e) The process of child development is an important one**

As the child grows these rituals are continued. Once the young boy reach teenage hood would he need to go for circumcision and this requires traditional preparation (*ukungcamliswa nokunyatheliswa*) where by the boy must also bite in a *mielie* comb that has been smeared with a bitter medicine (*umthathi*-very bitter medicine that brings a sense of purpose and had medicinal components ). This symbolizes that the young men must produce his own crop for sustenance of his family and the bitterness of *umthathi* also symbolizes that it will not be easy, endurance and patience is required.

**(f) Concern regarding to what undermined traditions**

These traditions were first undermined by religion and education. We were given bad education that undermined our traditions. That is why we are in this mix up and confusion. During the rein of King *Zwelibanzi* (the world is wide) *Soga* who was trained in Scotland brought religion and education and medical education through the Presbyterian Church. It was only in 1956 when *Madwaleni* hospital was built that women gave birth in hospital. Ministers of Religion and Schools these two institutions have destroyed people's cultures. They have confused a black person. We are going back and nothing is going to help. Christianity caused it all, now it has become a messy situation. We are holding on to our traditions while on the other hand ministers of religion who have not been selected by God are preaching about hell. You are never taught to preach - you are given by the spirits. A minister is supposed to be a prophet. They are not even aware that Satan has entered Ministry. The bible was introduced badly by white people. Ministers quoted from the bible and

made the bible God whereas God is hidden-no body knows who God is. There are many interpretations of who God is but the bible puts one interpretation. Satan is clever. He enters to those at the top. We will be seeing the Armageddon. In 1993 SA was in trouble. People had been looking for freedom, people were burnt. Were this all Gods will? Twenty years ago I dreamt of a beast. Where by this beast, kept changing its format with the head turning to be the tail and vice versa.

#### **(g) Elements of Amabomvane being a patriatic society noted**

During child birth, if it is a girl, these men would turn their heads away with disappointment if it was a boy this was received with jubilation and celebration. During this time women are not allowed to come to these celebrations only girls, we are not sure of the reason. We never asked why. We would be seen otherwise. A father is the head of family. Now women are leading and the man is deafted, God must be angry where he is (Is God a Man, this is an interesting issue). A child that is a girl is liked a lot by the devil - the devil is very jealous of this child. So he sends bad spirit to the house hold.

#### **(h) Perceptions regarding health care system beyond the home**

Beyond the home there was *amagqirha* (those that diagnose) and *amaxhwele* (medicine man). So when you are ill and cannot be assisted at home you go to *igqirha* that say what is wrong and then *ixhwele* prescribes medicine for you.

#### **(i) Aware of the challenges facing the village**

- **No production of maize:** Then Chief Xotongo lamented that we are going to experience a time where our sons will have no mielie cob to bite as there will be none as there will be no body to plant mielies. Also our methods of ploughing using cattle are undermined by the technology of tractors that we do not have resources to maintain once broken. Matanzima tried to introduce these tractors in 1994.
- **Liquor drinking by young people:** As young people are busy drinking beer in Taverns. We are in great danger. People in the village are selling liquor -beer. They do not sleep; these taverns are opened for 24 hours. If young people do not sleep, when you need to go to the fields to plough at 4 AM where will you get the energy. People from the top come hear saying they have licenses from government to run Taverns. ***This can be money to others; it is a health hazard for our children.*** Just imagine 9-11 year old boys drinking. Liquor kills nations; I have seen liquor delivered to people. Beer is made by the people. This country cannot go anywhere. ***Taverns in - health and agriculture down.***
- **HIV and AIDs:** When you are drunk you cannot think, this could be the reason why we cannot even control this HIV.

**(j) Challenge of new government structures and issues of modernization**

We have allowed the government to deal with issues, *whereas the government is the people*. You cannot even punish your child; government intervenes and says it is child abuse. I do not understand. Even the Bible says a child must respect his/her parents. At this point Chieftain Ntipeni Ndala took over the discussion. The Chief also used to assist with the aggressiveness of the youth. Now those powers have been taken from the Chief.

**(k) Interplay between health, religion and cultural belief systems**

In 1966 something happened to me. I was never converted to religion. A lot has changed. When I took people to pray for rain when it was very dry, I was asked what I was trying to do. Can I be able to change people? This is painful and it is at the core of people's existence - health. TB comes from the infected water many animals live there. I saw this through a dream in this dream I sent a child for water. I was in a pilgrim then and could only eat bread. The bucket that the child brought the water in had a dark snake in it a puff adder. It looked like oil. After this many people started dying. I asked Madwaleni hospital to allow me to come and pray for the dying people but the doctors said this as unnecessary. For example a child that is having convulsions a ritual should happen to unite with the beast that is causing this.

**(l) Perception of what is seen could be a solution in the present situation**

We can only survive only if we adopt *a backward and forward movement*. I asked, what is this backward and forward movement. He explained that we need to be allowed by those that carry the modern culture to go back and retrieve the good things about our culture and move forward with those and continue like that when ever we encounter a new modern concept we need to go back. Each modern concept must be underpinned by good old ideology. God has brought HIV to sort this out. Abstain is the answer. I abstained from food for a while when I was in trouble. You must pray to be saved that is why I abstained. Certain foodstuffs can be poisonous for example the yellow of the corn, chicken, red meat Etc.

Chief Vuyisile entered the discussion and said that he wants to thank Babu Ntiphela for his contribution. Everybody come with their own perspective how they interpret things.

**Meeting with the Paramount Chief**

I was accompanied by the Chief to visit the Paramount Chief. The Paramount Chief had a homestead as well as her own church. Though she could not read nor write she was always carrying a bible that looked brand new. I introduced myself to her and explained why I Have visited Gusi villages.

**Themes emerging from discussion with the Paramount Chief****(a) Availability of health services**

A person was never taken to the hospital when they were ill there were no doctors. In each family there was a healer a person who had to shut out the illness. ***The very 1<sup>st</sup> doctors only came when people had to be taken to the mines to examine them, then the person would be weighed so that they were capable in the mines.***

**(b) On traditional healers**

There are traditional healers that have studied to be traditional healers; there are those that get their traditional healing knowledge from spiritual influence.

**(c) Perceptions regarding her use of the bible**

Personally I hold the word of God through the Bible. We are holding an instruction via the Bible. I have nothing else except that message. I came from the hospital and I planted cabbage in the garden. Nobantu is a madam not a woman. Our forefathers gave prophets about coming times and we can see that these times are already here.

**(d) On a man who has recently died**

This man who is late is a rich man but he abuse alcohol somebody. It is bad that he dies in alcohol. He was helping people because he had a shop. People had to go into pilgrim when there was going to be a celebration.

**(e) Why are people not planting their gardens?**

It is the democracy. But democracy does not say a person must sit down.

**Discussion of the outcome of the meetings between the Chief, the Chieftain and Paramount Chief.**

This discussion was not far off from the literature regarding the Mabomvane tribe. The emerging themes showed that these three leaders are very much aware of the challenges facing the Amabomvane people and their health. They still believe strongly in rituals and ancestors. They are concerned about the lack of integration of their knowledge and see this as a disjuncture with regards to health. There is a general perception that exists regarding Christian religion, education and health in how this has undermined the IHK held by the Madwaleni people. The present health challenges of TB, HIV and Aids as well as emergence of new challenges such as liquor within the village life and change of governance from the Chief being the sole custodians of the rule of law to the emergence of wardens that are linked to central government appear to be huge challenges. In the prevailing problems facing the Amabomvane people, one was rooting in seeing the role that the female paramount chief was playing as a mediator in the patriotic society. Unfortunately the researcher found her to be engrossed with the new Bible that she could not read. In retrospect the researcher

acknowledges that to be a female paramount chief of more than fifty male chiefs is not easy, the Bible and religion that seem to have controlled the Mabomvane tribe might be useful as a tool to control these fifty male Chiefs.

## 2. The Pilot Study

### Presentation of narratives from the analysis of participants for the pilot study's narrative

#### (a) The home being the place where illness can be contained and managed

The husband of the caged lioness from observing her was sure that *the home was a place where illness can be contained and managed and was confident in management of illness within the home*. He explained that he had raised 7 children and he does not believe in doctors. He does not use medicine from outside his yard. My children do not have problems with illnesses even if they were ill I would sort that myself. It is only when they have broken bones that I take them to the hospital for example - he points under a tree where a group of young boys were sited with one having one of his leg in a plaster of Paris. He explained to us that he fell from a tree. He further explained that for example umhlonyane was good for chest problems, ear problems and for children when they are still young with white tongue. People used to steam with umhlonyane and umthobe and the illnesses would take two to three days to go away. They boil umhlonyane and boil it with a little bit of salt. With rash they used sheep droppings and ears to traditional people. For coughing they used (isihawuhawu). For stomach ache they nused ifaki. For boils they used zambuk and bread. Children with burns, eggs are used. For headache igwada. With teeth they used to clean with salt or ashes.

These healing practices are extended to other people outside the home as he explained that they helped other people outside the home with a whole variety of illness such as blood pressure and old people with arthritis and people from outside come and be helped by them. The husband of the caged lioness concluded by saying that there are no huge illnesses. All illnesses can be cured at home. This was further affirmed by the *quite deer that was caught in middle* who felt that there is no medicine used for the child except umle which is used during the birth of a child. Or isivumbampunzi for constipation and rash and sometimes one use sunlight mixture to spate the child. It appeared that from the *quite deer that was caught in middle's perspective*, these types of approaches were seen as not medicating the child but as caring for the child. She also maintained that there were *varieties of approaches to health and illness* some people sell chickens; others gather wood, whereas others pray and take children to the doctor.

Food and herbs could be grown from the home as the researcher was shown by the husband of the caged lioness her garden. The garden to her appeared like what she imagined the

Garden of Eden would look like. There were a variety of fruit trees, avocados, strawberries, tall shrubs with flowers and short ones blooming. He showed her umhlonyane, a tree for making castor oil, a tree with big leaves for putting on boils and swollen areas. He also showed her cannabis shrubs and he chuckled at how police are always querying their planting of these shrubs not realizing that cannabis grow like weed in that area. *The quite deer that was caught in middle* was able to expand the terrain where medicines can be obtained by pointing out that others grow by the river, a plant that one makes beads to put around the neck of the child as a necklace to calm him during teething grows well by the river. We were surprised that the grayish beads she showed us on one the babies neck, one of her grandchildren are seeds from plants and they used these for making small necklaces for the children when they are teething (We have seen these lovely grayish necklaces being sold in some of the flee market and never knew their origins and use in those origins).

*From the quite deer that was caught in middle's perspective there were also unknown and confusing illnesses that could not be contained within the home whereby the traditional healers were consulted. These were huge illness, such as children with stomachaches that cannot be sorted out at home, they were taken to traditional healers and they used umafunga. People with amafufunyane (this is a form of psychosis that usually attacks teenage girls and young women; they are seen as being possessed by demons). I asked how her three children died. She responded that, "The first one had stomach ache and I used both doctors and traditional healers. The second; I did not know and the third had again stomach ache".* It appeared that there was also a lack of concrete understanding of why certain types of illnesses ultimately lead to death. There was also shifting of lack of knowledge about illnesses to a higher being as this is shown by the response of the husband of the caged lioness when the researcher asked about the death of their first born, *"Even the first-born child that died it had to be; it was a very cold winter"*.

Other illnesses, their approach to managing them at home was more about containing symptoms than actually targeting and curing the condition as they explained that umhlonyane and isihawuhawu which are the two main herbs used for coughs in the Xhosa cosmology could be used for the cough in TB and cannabis intsangu can help to cure, chest and kidney problems and there are also herbs for seizures. Cannabis was used for smoking and for relaxation by the Rastafarian family and maybe the mental illness we saw that the wife of the Rastafarian husband was struggling with was a result of that smoking (there is some literature regarding the impact of alcohol, drugs and smoking on men versus women, in terms of tolerance to drugs, and the fact that women experience negative consequences of drugs earlier than men).

**(b): Child birth seen as part of the skills women learn, do and teach other women**

The researcher asked the daughter-in-law how many children she has and she replied two. She went to explain that the 1<sup>st</sup> one she had in the hospital and the nurses were in a hurry to get the child out and they cut (episiotomy). To her if they could have waited until the muscles were warm to expand then she could have opened up to give birth to her child without being cut. So what happened to the second one I asked? I decided to stay here at home and for Mama to help me. And how was that? It was difficult but fine. How did you know it was going to be fine and your mother-in-law would have been able to manage and help you with giving birth? I just new. I started seeing an excitement from the mother in law - *the quite deer that was caught in middle* that I had not seen since we started with the discussion. She interjected with excitement that ukuzala kunye - giving birth is the same and generic (this is a say amongst Xhosa women and maybe other women of the world, they say this to each other to affirm each other as women and also as a form of reminder that there is a common golden thread that binds all women together and that is giving birth, and each woman is expected to hold each child young or old with the same empathy and care they would hold their own children and give guidance to every child as if it was their own).

Makoti (that is the name given to a young daughter in law) gave birth on her own because she was afraid of being cut at the hospital, the mother-in-law explained. She continues to say that you do tell your mother when labour pains start then she can prepare a matras on the floor for you. She put a plastic on the matras and a sheet on top. Then stay with her to guide her on what to do. The first child she was operated - the episiotomy seen as an operation. This operation which I have observed nursing sister doing quickly without even asking the client once they feel that with further pushing the head of the baby while coming out will tear the vagina. Then after the child had come out, they would quickly put local anesthesia on the open wound and sue the vagina. To this family this was not a small operation and due to this a line had been drawn in terms of having or not having a child in the hospital. I asked the older women in terms of what makes her confident that everything was going to be fine when assisting her daughter-in-law with giving birth. I expected that she will say she knows it from god as she was saying with traditional herbs, but she just said she is not sure what makes her feel confident but she new everything was going be just fine. She has just recently assisted her other younger daughter with giving birth and the child is thriving but the mother is still not doing that well.

The quite deer that was caught in middle when asked how did she knew she was it going to be fine seemed to overlook that she had already explained to me and said that, "I was shown twice how to give birth of my own children by older women and the third child I decided to do

it on my own - she gave birth to my own children at home.. How did you do it? Once the labour pains start I would start being busy to hasten the whole process and once the baby is close to being born, I would call a child to play close to the house so that once the child is born. I would ask him to call the neighbour to come and see if every thing was fine. I would use a sharp stick to cut the umbilicus from the afterbirth. Already I would have dug a hole to bury the afterbirth". Then I would take this to bury it. It appeared that she learnt about childbirth from other women - then practiced it for herself - made it a point she was safe while doing this by placing a child close by to call a neighbour in case something went wrong and then applied that knowledge to the daughter-in-law.

*The Prancing Peacock* further expanded that when a child is being born, a fire is built so that the child does not get cold. The headscarf should be loosened by all the older women in that room including tight clothing. When the child is on its way, a large amount of hot water is prepared and ischakathi is prepared (mild diuretic to get the first stool going from the child). The child is given this mixture with celebration and saying Huntshu once the child is born. Medicine would be brought from the field (amagungqu) and the child must drink this medication also older people should drink it first to test if it is fine. A child can only take a teaspoon of this whereas an adult person you can give half a cup. Iqungqu need to be combined with umthombothi to get out ishimnce-the rash that the children usually develop after birth and thulumi to get evil spirits out.

The child grows, time and again we conduct some rituals to strengthen the child so that he does not become ill but sometimes when he become ill we take him to the hospital *the Prancing Peacock* maintained. When he is having fits, we give him the big aloe, she stood up to show us the type of aloe she perceived to be goods for fits in her garden. Then how did you manage your own children we asked her and she replied that, "*I would manage all illnesses at home I would not go to the hospital. Then the child will go and get married. When she is getting married, this marital exchange there is a need to slaughter to celebrate the uniting of two families*".

**(c): The Union of two families is never that simple - house holds tend to hover between strength and vulnerabilities.**

In the house of *the caged lioness*, as soon as we packed our car in front of the gate a middle age slender coloured woman - *the caged lioness* met us at the gate. It appeared as if she has been waiting for ages. The researcher's sister was very much acquainted with this family and as a school teacher in this village had tried to convince this Rastafarian family, that their children should attend school. This woman greeted the researcher's sister as Aunt Hazel, imitating her children's manner of addressing her. The researcher's sister asked how she

was doing. The women started speaking in a very loud voice blaming the researcher's sister of neglect when she was in need. She spoke of being persecuted and people with big cars and big moneys coming to take her children away and put her in jail. She totally ignored us and dragged the researcher's sister to the house, as she wanted to show her what has been going on. We followed from behind. She said there was a time she was in jail and what kept her was her Rastafarian faith and God. The house was a three roomed house and in such a bad shape that we were wondering where these people spend their day and night because of the level of confusion that existed in each room. The husband joined us, a lightly build middle-aged man. The researcher's sister asked how he was doing and explained why we were there. As soon as the researcher's sister shifted her attention to the husband, the wife started throwing a tiered of insults to the husband. The husband took the researcher's sister to the side and tried to explain that his wife has totally lost her mind and this is the type of situation he lives in. If we require any knowledge, he would be the best person to talk to. The researcher's sister said that she would not to be part of the discussion, as she wants to try and reconnect with her friend the wife who was renting. Her intention was to gain a better understanding of what was going on with her. She went inside and drew up a chair in front of a paraffin stove whereby a medium aluminium pot that appeared black from not being cleaned was cooking something. Hazel asked if she could see what she was cooking as again a form of investigating the state of comprehension the wife was in and the wife said she must go ahead. It appeared that she was cooking pap that did not look appetizing at all. We left the researcher's sister with her to sit outside not very far from the open room they were in and from where we were we could hear her complaining about everything on earth and how she was being persecuted by everybody sharing again with her fear of losing her children.

As we were leaving the household of *the caged lioness*, we noticed three girls that were between the ages of 8-12 sitting on trees. They were beautiful with rosy cheeks and long brown to black curly shiny hair, they looked well nourished and they were warmly clothed with also good tacky shoes on their feet. Hazel remarked that these are some of their children. She talked to herself that her major concern was the children especially the girls. Both of us agreed that though they looked well looked after but we still felt that anything could happen in that environment. She promised herself that after Easter holiday she need to consult with the social worker whereby for a while the children could be taken to a place of safety while the mother receive treatment for her condition. We left this household feeling shocked, confused and concerned at the situation we found.

*The quite deer that is caught middle* explained that daughter is still weak after childbirth. She asked for her to be called. When she came in, she looked clean and well groomed but extremely weak. We were concerned and asked if she has seen a doctor or gone to the clinic and they declined. We pleaded with them that she might require proper check up. We asked all questions related to problems of giving birth to try and see if things did not go badly during birth and everything seemed to have gone well that side.

**(d) As the middle generation dies of HIV and Aids and other social hazards, the care giving of the third generation takes its own toll to the grandmothers**

The researcher's sister explained to the researcher about the grandson of the Prancing Peacock that he was ill and refuses to take treatment while staying with the grandmother, as he believes she has bewitched him and also she is the cause of his parent's deaths.

The researcher learned later from the researcher's sister that he suffers from HIV and Aids and both his parents died of this. The researcher's sister explained to the researcher that this is due to HIV and AIDS. None of the older Xhosa women talked about the cause of death of their children except that they were gone. The first thing the Prancing Peacock explained was the situation explained above of her grandson not staying with her- this was explained with such sadness and a bit of a feeling that she has failed somehow and she grabbed that lately they get infected with HIV and AIDS because they do not listen to their parents. That day the researcher saw 4 older women in their house holds and only in one house hold there was a middle generation and even in this house hold the son who was a first born and his wife were dead.

According to the hurting sheep this did not mean they were not dating, they were dating and even when they were caught in their passion they were sure there was no penetration and only do deep caressing between the thighs and this never happens in the girl's home but out in the fields. The boy who is interested in you would look for an opportunity when you go to the river to pick up water or wood from the forest and he would follow you. Then he would play with your wrists until they are sore because he wanted you to agree to be his girl friend and you would go back home with sore wrists but still being expected to make samp out of maize by hitting the maize in a wooden container with an iron rod until it is ready to be cooked. You would use these sore wrists and you could not tell your mother that the wrists were sore.

The hurting sheep said that, *"I am raising children with using an old age pension. I also use this grant to see that they go to school so that at the end they can help themselves. Their mother left them by drinking car battery water. She was also head over heels in love with this*

*married man and I could see that this relationship was no good*". The laughing Bear also commented that this whole problem of raising grand children as if you are their parents it is difficult, they were not used to this thing of being parents. She further expanded that the types of demands they put on them, it was difficult to meet by saying, and "*What do you say? You cook them a dish and type of food they will not eat it and they tell you that they cannot eat that kind of food*".

The researcher further asked from the laughing Bear what was the relationship of her mother with her children as their grandmother. What did her mother used to do to her children when they were demanding? She replied, "*It was by choice. They were not forced by situations to do it. A grandmother is a second person in the life of a child not a first person. Children need their parents. What do you do when your children are dead*"? She further answered herself that you do the best you can. She further expanded that today children want canned food, whereas in the olden days they used to eat simple food even samp without beans and they would not complain, they would be satisfied. She further complained that the schools require children to put on shoes and high school fees, while during their time they did not care about shoes as long as they went to school. Though grandmothers knew about herbs children of today want to see a doctor they do not even want to go to the clinic. She mused to herself that grandchildren are changing things.

*The lioness with clear boundaries* saw this slightly different that it is a myth that children of today are worse than children of the past. Children must see you as a role model. You must be clear of what you are saying. But she also agreed that children of today lack parental guidance. She explained by saying that, "*Here in my home they understand me and what I want. I say to them both mine and my grandchildren once the sun goes down everybody must be inside the yard. I have educated children now and some of them have degrees but some are dead*".

**(e) The challenge and toll of care giving the third generation and loss of indigenous knowledge make grandmothers long for the reinstatement of old values**

The prancing peacock stood up and started saying in a loud emotional voice that we need to go back to the manner things were done in the olden days (Masibuyeleni kundalashé). The researcher asked what is now different. She explained that during their time parents used to make sure that girls are safe at night in the household to prevent pregnancy and she still does this with her grandchild. Girls must be checked if they have not massed up with boys and lost their virginity and during those days it was a shame to lose your virginity. The researcher further asked is she saying that we need to go back to the olden culture. The prancing peacock said she do agree completely with that. She further expanded that before

girls never slept with boys in their homes. She concluded that it is important that girls look after themselves and abstaining is the best contraceptive.

It was at that time that the researcher's sister chipped in to say that the older people should realize that it would be a challenge to go completely back to *ndalashi* as the home situations themselves have dramatically changed. For example if girls are subjected to virginity tests, what about that girl who is subjected to sexual abuse over and over by an uncle and this girl might be carrying a load of looking after younger siblings because the parents are dead because of AIDS and the uncle might be the only available relative. To subject this girl to virginity test is like shaming her twice and this kind of approach is not necessary for her, other approaches are needed to intervene in her difficult painful situation. It became quite in the room as if the age of innocence has left us.

**(f) Elapsed time tends to make grandmothers forget the difficult problems of the past especially in the context of intimate relationships.**

The hurting sheep maintained that her husband was working in Umtata. There he got a girl friend for himself. Then he did not come back home for months and also did not send money so she decided to go and check at his work on payday. His employer was surprised to see her. She told him of her predicament. He asked her if she would like him to hand over his salary to her and she could give it to him she said yes. She went back to where he was staying and She found the girl friend there, it was an awkward moment. It was not long before her husband came in. He demanded the money and she told him she will only leave him with R20.00 since for months he was not sending any money home and she had lots of money related problems to solve at home. Once she reached home she decided to forget about her husband and raise her two children alone - there by in a way shouldering the whole caring for the family on her own.

It also appeared that the caring expectations were also expected to be executed even to those husbands that have transgressed. There was expectations from them that since the wife had managed to keep his household and family going while he was enjoying himself somewhere, when structures around him collapses his wife should be a safety net for him. This is supported by the comments made by the hurting sheep in this quote, "*Then one day I heard a noise outside and it was my husband's brother with my husband who appeared to be very ill. He said he had brought him home, as he cannot even work. So I heard to take that big responsibility of looking after somebody who had hurt me so much. There were moments of looking at him with so much anger and he would be looking at me with pleading eyes. Also his sole took long to get out as if there was something he was asking from me.*"

It appeared that the unevenness in scales between women and men at that time was outplayed even in daily relating between husband, wife and children as the dancing bear commented that, *“You would never speak with a loud voice to your husband you could not even call him by name he was called Bhuti when there was still no children and by the first born’s name when a first-born was born like the Father of so and so. What was not good was the relationship between your husband and his children. It was distant and cold even when coming from work with nice things for the children he would give them to you to give to them - this was not good. This relationship could have been worked better. The children ended fearing their own father”*.

It appeared that this form of fearful respect for the husbands of these older women was continued beyond the grave as the dancing bear commented that, *“When the husband dies, you look up to heaven and continue looking after your husband’s cattle and well being of your family. You see the fact that we listened to our husbands when they were still alive continues even when they are dead”*.

This notion is also supported by the hurting sheep as she says, *“After his death his mother followed and I took one of the best cows he had instructed me before he died that I should give over for burying his mother. His brothers and sisters were shocked that I was doing this considering the way he had handled me and also that he is dead now and I could do what I wanted. I couldn’t, this what he wanted, and so be it”*. It also appeared that the notion that women must always be responsible is framework that is carried by the older women and is utilized as a yardstick during the raising of grandchildren that were girls, if they lose their virginity or get pregnant they were held responsible for not wading off the sexual advances of boys.

These intimate relationships were also difficult for the middle generation as the researcher’s sister explained to the researcher about the life of the Rastafarian couple which she described as having been a turbulent relationship with him playing between a loving and an abusive husband and moments of being jailed for his abuse of his wife. Similar to the Grandmothers, the wife of this Rastafarian couple has done a lot in developing the farm and planting herbs and a major part of this healing he talks about was done by her. But when the husband was accounting for their success as healers, no mention was made of his wife - even that raising of his seven children, it was as if he was doing that himself. On the other hand Rastafarians wife had natured a relationship with researcher’s sister and these two women has supported each other in the growth and development of their children even the process of accessing child care social grants. Again there was a concern that since it was difficult for the mother of the children to be fully in charge of her caring activities, this satisfied

him and he was enjoying being in charge of these resources. The researcher also remarked that the husband also appeared to be too much in control of the fracas that was going on there and when he was remarking about his wife condition he appeared to be too calm about it with no plea for assistance. From the researchers perspective, it appeared that the tables were turned against this women as she was no longer in charge of what was going on in her household and she also in the beginning might require some form of institutionalisation. From the researchers reflection of the experience she draws from women that have made an impact in her life, it appears that the tables are always turned against women - are women the victims of their own making as it appeared that there is no form of accountability they asked from their husbands and even when raising grandchildren a lot of emphasis in terms discipline was put on girl child.

**(e) Grandmothers have assets to continue caring for their grandchildren despite the challenge of losing their children and changing times**

*Strength and resilience*

The researcher asked the hurting sheep what give her so much strength and she replied that the need to do things for myself. She explained even when her husband was alive she used to cut grass for thatching her household and sell some to other people and the researcher asked what is the driving force behind and she replied that it is being a confident independent woman. She is used to doing things for myself, even with her own children the money she used to get from her husband she used for buying them clothes and for food she used to plant vegetables and plough maize.

*The lioness with clear boundaries* felt that this strength comes from being proud and collected and being at home - so having a home does have a greater meaning. She further explained that when she is in trouble she kneels down and ask for strength from God. She felt there is nothing new about the present challenges of life - Life has always been difficult, but then one does not give up, one continues. The researcher asked her where she got the strength to continue. She replied that Maturity brings this strength and also your up bringing.

The researcher asked the Dancing Bear what makes the older women to be closer to the grandchildren and look after them. She responded that that is how the older women were actualized by their grandmothers; *it is always coming from the back*. The Lioness with Clear Boundaries further expanded and said that, *“my husband is dead but on the other hand I am still alive. I did not come here for him but to look after the children we have made and his home and cattle. Children are the fruit of a marriage and they are the most important things not the husband.”*

The researcher further asked the Lioness with Clear Boundaries what it is then to be a woman. She responded and said, *“It is to humble oneself and endure but also being able to be selective, what is good from bad. A woman is a peacemaker. Then what is it to be a grandmother? It is to gather all your children and assist with their well-being. When you are a woman you do things for yourself whereas when you are a madam you sit in a sofa and do a leg up on leg and wait for others to serve you then take your car keys and drive around. As women you raise all children as if they were your own.”*

There was also an impression from the grandmothers that since the middle generation was gone, the grandchildren are the only people that will look after them when they are no longer strong, also they had a perception that something good will come out of caring for the grandchildren as the hurting sheep said, *“Now I am busy assisting my grandchildren to become educated so that I could be buried properly and also that they should bring light.”* The researcher asked what happens if she never had children? She responded that it would have been a great pity. According to her when you have given birth your name never perish.

The proof of this continuum of caring was shown when the Dancing Bear wanted to show the researcher’s sister how much her grandson had grown and she has just made a birthday for him and we need to see the pictures. She went off in a hurry to fetch the packet of photos. It appeared that the children had a goodtime that day of his birthday. There was a huge birthday cake on that day. It appeared that the grandmothers with their pension money seem to be reaching all levels of trying to make sure that their grandchildren without parents do not feel as neglects.

#### Self discipline, patience combined with hope and trust

The Prancing Peacock was sitting outside waiting for us since 10h00 the time that the researcher’s sister promised that we would arrive, it was midday now. The researcher and her sister were embarrassed about how late they were and the researcher’s sister asked if she could still talk to us and she responded that what would be gained by not talking to us as she has almost wasted a full day waiting for us? The Prancing Peacock was aware of the highest action - and again she selflessly gave to us unconditionally. The researcher’s sister apologised for us for being late and went again through the process of explaining our purpose for the meeting. She asked if it is still fine to conduct the discussion.

Because we were late for the first meeting and we were late for all the subsequent meetings to this meeting. We were gracefully pardoned by all the older women as we went along. We also find out that the older women had prepared for us up to the last detail. They have cleaned their houses and swept their grounds and polished stoops - they were very proud of

their homes. As we were in the house hold of the last but one older woman's house and we have just finished our cool drink we thanked the older women and shared with her that we are doubtful that we should conduct the discussion with her neighbour who live in a house above hers, about a minute from her house hold as it was approximately 18:00 and we were feeling tired. She discouraged us severely from this idea as she felt that her neighbour would be severely disappointed. She was absolutely correct her neighbour had prepared for us up to the last detail for our meeting with her; not coming to her household would have been a huge disappointment to her. It appeared that the older women in terms of patience, generosity of spirit, trust and hope, they still hold strongly to these values.

*Caring, respect and cleanliness also extended to visitors.*

In the household of the quite deer that is caught in middle the previous day we were taken to one of the round huts. Inside everything was in its place and it was very clean with shining pots put on a sideboard. Then her daughter in law came in with a tray of tea and freshly baked bread. We were very grateful for this as we last had breakfast and it was now after 16h00. We were given a fresh pack raw mealis when we were leaving. I was asked to take back the girl we came with together with two boys who were going to spend Easter holiday with their mother who work in Umtata. I obliged.

The Prancing Peacock took us to a two-roomed flat, which again was spotlessly clean with shining ports and a brand new television. In the house of the Laughing Bear the steps were nicely freshly polished with red polish. The house which was a combined lounge and dining room was freshly clean inside. The Lioness with Clear Boundaries took us to a three-roomed house that again was very clean and with quite a modern furnisher. She told us that she thought we would arrive at 13:00 and she and her family had prepared lunch for us and they had to eat without us. Freshly baked scones and coke cola was brought in and I enjoyed the scones.

Despite the challenges they were facing of raising their grand children they gone ahead and prepared refreshments and food for us as we discovered that the laughing bear was ready with cookies and cool drink that were brought in for us by a teenage girl of approximately 13 years old. She also looked well nourished and simply nicely dressed. The researcher's sister congratulated her for looking clean especially during school holiday as during this period many of the village children do not border to wash and groom themselves. In the household of the Lioness with Clear Boundaries trays caring food came. It appeared that they had warmed the lunch we could not have with them. We also noticed that the chicken meat was from home grown chicken. We thanked them for their generosity.

**This generosity and what** Hazel has looked after the last born who was a girl while schooling. We came with this girl and dropped her before we went to the farm so that she can announce to her mother that we were coming. **Rhythmical sharing of resources and support.**

*The use of self sacrifice to overcome obstacles*

*The lioness with clear boundaries* expanded that there was a time she would go to the forest to fetch wood to sell for the survival of her family. She would also make bricks to sell so that my children should go to school. All this has not been easy for her; she explained that for example, she wanted all her children to get educated. Two of them got pregnant while they were training to become teachers. She decided they were not going to stop with their training, so she took the grandchildren and raised them. Now they are finished.

She continued that two of her grandchildren are disabled. The researcher asked her how did she managed, did she feel it was more difficult for her to raise disabled children. She responded that her biggest problem is that she felt that outside they were not understood and this was very painful for her. She felt that God had deserted her. Also as their grandmother she could not see this big fuss. So the boy who had cerebral palsy I made sure that he went to this school that Mrs X (the researcher's sister) is a principal. Then she discovered that there was a special school Evela and she took him there and there she maintained he was progressing nicely and he had learnt to drive and can see that he is happy. She expanded on the grand daughter that, *"This little girl-there was a group of children standing by the door inside and I could pick up that one of them it looked as if she has knocked knees and reconstructed clubfeet. I decided that from the beginning she would attend normal school. So I would put her on my back and while taking her to school drive the cattle to the fields. Then I would drop her first then take the cattle to the field. Then again I would fetch her."*

**(f) The use of 'changing times' as opportunities to blend the past to the present and give grandmothers hope for the future.**

The Dancing Bear came back walking with a waddling duck like gait. She started by smiling at us and saying, "I was already giving up on you and if you had not come here tomorrow you would have not find me because I would have gone to see my husband". The researcher and her sister simultaneously looked at each other as both had an understanding that the older woman was a widow. The researcher's sister asked who her husband was. She stood up and started dancing and singing that don't we know that President Mbeki is her husband, the husband of all older women. Have we ever seen a man who without failing put food on the tables of older women? She continued and said that Mbeki is our husband, monthly he gives us money, he is doing something our husbands failed to do while they were still alive. Now

these husbands are late. But with us unlike our mothers we have not felt the biggest challenge of being widows because with us we do have a husband. The researcher's sister sang Hallelujah and said she wished president Mbeki was there to hear all these good things said about him. Again the researcher got the same feeling of expanding from inside and floating outside as a revelation came to her. She felt that the term husband would forever have a deeper meaning to her and be associated with dancing, happiness and satiety that was shared with them through the older women perception what a husband is to her. The death of the middle generation as well as their migration to urban areas had taken its toll on the older women as we see them faced with raising up the third generation. It appeared that the social grants offered by the Social department of SA offers the grandmothers some form of financial relief.

The Prancing Peacock was so proud of her television set that she has bought with part of last month pension allowance for her grandchildren. She said to the researcher's sister that she is following her suggestions. It appears that the researcher's sister is encouraging the parents and grandparents to use the television as an educational tool and spend some quality time with the children watching and explaining about the story behind each programme. The researcher silently wondered about the integrity of all this. She remembered when she was raising her own child how much television was discouraged from the school of her own child. She also knew that other parents with young children including her neighbour in Cape Town - television for their children was a no-no. There was a perception that television undermines the thinking process of young children. It also limited movement that was required for the development of children. The images on the screen of a television also move too fast for the children to fully comprehend the picture and children stored these images and replay them at night during sleep. Having said the researcher could also see an opportunity for these orphans and their grandmothers that: (a) Stories of hope and healing could be played in some programmes of these television sets to assist the younger people and their grandmothers to heal from having lost their loved ones; (b) Programmes that encourages activities for the children could also be put in television programmes; (c) and lastly as a form of bringing children together and fostering the spirit of being a community the government could give out a social grant and create entertainment for the children in community halls or schools with bigger screens and this could be interspersed with other activities.

The loss of middle generation could be used as a window of opportunity to explore good traditional practises with the older women playing a key role. Such suggestions had already been made by the Prancing Peacock as noted in the following paragraph. The prancing peacock turned around and faced the researcher and looked the researcher straight in the

eye and asked her what she is going to do with what she has said that we need to go back to *kundalashé* (go back to the old cultures and practices). The researcher felt a bit trapped, as she did not ask her what she was going to do with the information but what she was going to do with the fact that she said in terms of health issues we needed to go back to old traditions.

There were many reasons that made the researcher feel trapped. Indeed it was clear that bringing back *dalashe* was not as easy as that as the very social structures that made it possible for implementing old traditional practises had been broken and relationships that used to nature the processes that facilitated the implementation of these practises were severely undermined as shown by how the researchers sister responded to the older woman, It was at that time that the researcher's sister chipped in to say that the older people should realize that it would be a challenge to go completely back to *ndalashé* as the home situations themselves have dramatically changed. For example if girls are subjected to virginity tests, what about that girl who is subjected to sexual abuse over and over by an uncle and this girl might be carrying a load of looking after younger siblings because the parents are dead because of AIDS and the uncle might be the only available relative. To subject this girl to virginity test is like shaming her twice and this kind of approach is not necessary for her, other approaches are needed to intervene in her difficult painful situation. It became quite in the room as if the age of innocence has left us.

It also appears that the older women were not aware that both the educational and religious influences that have come with missionaries in their regions as well as general changing times had also made the older women not to be so much open to old traditional practises as the researcher had to plead with some of them in terms of opening up on their knowledge of traditional herbs as it is shown in this paragraph. The researcher asked the quite deer that is caught in middle if it was possible that we can open the door and look at before she became religious and there were no available hospitals? Could she kindly allow us to do this?

What about the time there were no hospitals? She replied, "*Ooh you mean before, I closed my door on traditional practices, I am religious person now.*" All this was reported in the second person or as "they" since as a religious person who uses the hospitals and doctors, she no longer practice all this. Did the neighbours or somebody with IHK not assist you when your children were ill, the researcher continued probing? She replied, "*No. Before I used traditional medicine now I pray every problem I throw to God.*" This is contradictory as it has already been shown that the quite deer that is caught in the middle acts as a birth attendant for her family and uses traditional methods of giving birth. If there is any hope of success in returning to *dalashe*, openness will be required on what is being used and what is not being used.

**Closing statement**

As the researcher and her sister were going home tired but happy in having been part of such enthusiastic trying older people and completed that task for the day, it was late and already dark outside. They also noticed that most of the homes were having electricity as already house lights were on. The researcher remarked that even if your car was broken you would be able to work your way to the village to call for help. The researcher and her sister felt that somehow even if it is happening slowly, there is a change. The researcher and her sister agreed with the dancing Bear that they did have a husband. Both agreed that President Mbeki. should not be only *myeni but* in every government office we need *abayeni* (husbands). The researcher's sister started singing again, "*Hallelujah mayibuye iAfrica-Hallelujah Africa must come back.*"

## Appendix F: Process of validation of data

Validation for the FGDs happened in the following manner:

(a) *During FGDs* the OXM would engage on a discussion regarding a certain concept and they would go round and round until they all agree on each concept on the other hand when the researcher further observed this process, she further discovered that there was an element of affirmation of each other, with this affirmation, another new point would emerge then again the process of going round and round affirming this knew point would continue until full agreement again had been achieved. When she looked at those contributing less she could see their eyes shining as if they were exposed to something new. This reminded the researcher of her youth days when watching traditional healers during a diagnosis of a ill one; they would say something that is related to the ill person in the form of a differential diagnosis, then they would say “Vumani” (You must agree, where by the traditional healer wanted affirmation from the relatives who knew about the illness of the love one even better than the traditional healer who needed to connect with his unconscious to develop a differential diagnosis, Clough has spoken about how IHK has been erased from the conscious and how through ethnographic studies it can be brought to the open and be emancipated). In this way though the researcher had an interviewing schedule, this was used for prompting here and there. The older women took the ethnographic methodology of this doctoral thesis and made it their own.

(b) *A feedback workshop was conducted for each FGD*, with validation of data and the filling up of gaps. This was done for the two FGs that have contributed most to the core research question of this doctoral thesis. Not all women were present that were present in the first FGD. In the FG that was the third farthest away from the hospital, only six women were present, instead of the original twelve. The FG that was farthest away from the hospital, only two women attended. For the researcher, this was appropriate as the women who attended during the second round were the ones who were most concerned about the loss of the indigenous health knowledge carried by the older Xhosa women, and who contributed the most during the FGD. By this time, the researcher had already transcribed the data into loose categories and themes. She read this to the OXW who went back to through the methodology of validation of this data. Less contentious than the 1<sup>st</sup> round, the researcher propose that this was due to the fact that this was a period of validation of a knowledge that had been previously validated through the method explained in (a) and also the women that

came for the second time in these two FGDs, the researcher would propose classifying them as elitist women, due to vast extent of knowledge of healing abilities within the home situation.

(c) *The two FGs that were closest to the hospital* These two FGs had the least to say about the management of HP within the HS. The researcher used them to validate knowledge shared by the OXW from the two FGDs that were far away from the hospital. All these OXW seem to have a perception that the management strategies of HP within the HS used by the OXW were outdated and they take their relatives to hospital for all these ailments. Four issues came out during these feedback workshops which the researcher perceives were worthy to be noted:

*Issues that came out from the group directly close to the hospital:* When the researcher started discussing the issue of severe alcoholism in the area one of the older lady seems to perceive that to try and make Madwaleni people stop drinking would be a problem as alcohol is one of the ways they link with their ancestors. She turned to the researcher and asked in your Christian churches don't you drink wine as the body of Christ, why then do you want us to stop drinking umqombothi (Xhosa beer).

The second incident again on this group was when the older women started suggesting to one OXW who had her rondavels fallen after heavy rains and was sleeping outside that she must make bricks to rebuild her home and they will assist her once she starts something for herself. This OXW turned on them and asked don't they understand that the doctor said that she must not do any hard work because of her sore back. She is going to go to the hospital to report them as they are contradicting the doctor's instructions. It was clear from this woman assertion that a punishment awaits these women for having transgressed the doctor's instruction.

This group again though they were grateful of what the hospital was doing seem to think that the hospital brought disease to Gusi villages, and since the hospital is the bringer of disease, they might as well deal with all the disease and cure them. This seems to be similar to the situation described by Mlenzana in CHCs in Khayelitsha whereby overcrowding was a problem and clients seem to think that the CHCs were the best places to contain all these ailments.

*Issues that came out from the group second close to the hospital:* Though these women were saying that the management strategies of HP within the HS used by the OXW were

outdated they took their relatives to hospital for all these ailments, there seem to be a certain level of excitement in the room as they were reminded of management strategies of HP within the HS that were used in their homes and they kept discussing and reminding each other of these healing strategies. Clough (40) speaks of the power of ethnographic studies in feminist studies in unlocking knowledge that is hidden in the unconscious and bringing it to awareness. One woman started claiming that it is not that honky-dory within medical care and sometimes Madwaleni hospital fails to cure their relatives of specific disease and it is during these moments that when a person is in the hospital they will quietly bring their own bottle of medication from indigenous healers and this bottle the ill person, must hide and the doctors must not see or they quietly borrow a person to say an important relative has arrived, knowing that they are taking the person to an indigenous healer.

(d) The researcher further used the elitist women for validation of data the elitist women were quite reluctant to speak about their management strategies. The researcher wanted to gauge how they would react and engage with the understanding that though they were reluctant to talk about this knowledge OXW from the home situation has revealed that much. Again the researcher noted a level of excitement from these women as the researcher went down the list of the management strategies used by the OXW; these women did not speak about these management strategies being out dated but pointed out to some being dangerous. They spoke about lowered strength and weak blood in people where by in the past they could tolerate such aggressive treatments such as sea water to facilitate cleaning of the stomach, they maintained for a client with diarrhea already this might be dangerous to use such approaches and it is better to take the person to the hospital. They affirmed that the OXW in other management strategies for HP within the HS.

## **Appendix G: An acknowledgement of lessons learnt from women who were my early mentors**

The need for objectivity during my interpretation of data from the older Xhosa women required that I reflect on five (5) women who I regard as my early mentors and how they dealt with health and development issues. I would like to mention that my life as a whole had mainly been dominated by women, so it would be difficult to say that this one or that one exclusively had been the main contributor in my development. Despite this and with regard to this study and the stance it takes, five women come to mind. Below presented in my chronological development is my narration of my reflections of lessons learnt during my encounter with them:

### **My maternal grandmother: The spinning sage**

To me my grandmother was the epitome of an educated person as she appeared to have no boundaries and limitations in her knowledge and its application. Practical application and explanation was valued more than beating by her. Schooling and accessing information such as reading, listening to the radio, specifically to the news, read newspapers and magazines and play games both inside and outside the house. The truth was a core principle for her and I later learnt for myself that this is a fundamental principle in research. With her agricultural knowledge, she made us realise that a home with a garden could sustain the family. Despite suffering from bad chronic asthma she lived until she was 73. She used herbs such as *umhlonyane*, *camphor* and *aloe* to open the chest and loosen the phlegm. At night we slept with windows open so that we could breathe in fresh air. In all the years that I was with my grandmother, she never went to see a doctor despite what is seen as one of the worst chronic progressive illnesses. It appears that my grandmother was my practical foundation.

### **My mother: the laughing bear**

I recall my mother's laughter, energy and purpose. Her children, work and spirituality was became the focus of her life. My grandmother wanted us educated and much as this was her wish, she could not operationalise it - my mother had to take this plan and implement it. All her children are professional people and we even had a medical doctor in the family. Caring was at the center of her actions even the execution of difficult action were done with care. I think I gained an understanding from that early age that there is the possibility of carrying out critical events and incidents effectively but still with care and tenderness.

She instilled the principle of finishing things and working in a process. Challenges had to be faced head. Despite this she instilled in me the value of acceptance of ones self. Whenever I

come to a point of severe self-judgment or find myself judging others too heavily, I usually return to this safe space of acceptance of self and one's own shortcomings while also trying to accept what I perceive are the shortcomings of others even though it is not easy. It appears that my mother touched my soul.

### **My surrogate mother: the focused sheep**

I call her surrogate as when I was about to enter Grade 6, I was integrated in her family just an hour's walk from a good reputable school. She became my second mother. She was childless. During those days it was always the woman's fault if there were no children in the family. She humbly carried this yoke of shame around her neck while relatives were glad to dump their own children in droves at her home, mainly I think because of her kind heart and also as a manipulation that as a barren woman she was not expected to complain. From that young age, I saw from the life lived by this woman how the scales are really tipped unevenly against women. I learnt a lot from this woman who was a nurse. I learnt about cleanliness, balanced food and daily rituals such as having three balanced meals a day. According to her, if you maintain this rhythm, it is not necessary to use laxatives - she was against laxatives and saw them as disturbing the harmony of the stomach. She believed that if the stomach is upset, allow it to sort itself out - *she believed in the body sorting itself out*. I saw humbleness and humility being played out over and over by this woman during the time I was under her wing. She always knew the noblest action must not be held back by personal angers. When my dark forces of vengeance and anger cloud my integrity, I always go to this abundant humility and everlasting love, a love that knows no boundaries and limitations.

### **My professional mentor: the dancing eagle**

I chose to be a physiotherapist and I will not go great length trying to explain why. My mother commented one day that since I had qualified as a physiotherapist she sensed a certain sense of purpose in the way I moved and carried myself. I was always at logger heads with our Head of Department as we appeared not to ever agree on issues. So, what did I learn from this woman who appeared to be struggling in dealing with me? I learnt about physiotherapy, I learnt how to breathe in deeply and in a shallow manner and how to punt and how each situation requires a different breathing style. She thought me about body movement and that when you are in action body awareness is critical as the success of your actions also hinges on this awareness. She later invited me to come and lecture in her department. This was a critical turning point for me. Unfortunately, by the time I left my sweet rural area and became a lecturer in her department, she had died of a heart attack. Hence, I fell into the hands of the next woman who mentored me into academia.

**My second academic mentor: the feisty, spirited black dove**

The first thing this mentor introduced to me was research. Although research was a paradigm feared at that time, she removed all myths around this subject. She made me aware that we were all born as researchers, otherwise the human species would not have survived. She used to cajole me and say in academic circles our voices must be heard. You must have an opinion and contribute critically during debates and be part of the development of academic knowledge. She opened my critical thinking. She made the synapses of actualisation that were given by some of the mentors I have mentioned join to form a whole. She taught me to argue from a full cup and connect with the truth that my grandmother had drilled me in during my humble beginnings.

As I end the reflection on these prior experiences and enter the research in the indigenous health knowledge carried by the older Xhosa women, I hope the reflection on these prior experiences will assist me to achieve an objective critical stance in this doctoral thesis.