

**A sociological analysis of the Rhodes University Students and staff members' perceptions on the use of traditional medicine and biomedicine**

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By

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## Declaration

This is to declare that everything that is written here is the work of the researcher and that everything that has been abstracted from existing literature has been referenced

## Abstract

The primary objective of this study was to understand to the role that discourse on traditional medicine plays in the choices that Rhodes University students and staff make regarding who they consult when they are sick. A secondary objective was to explore the participants' views on the Department of Health's draft policy on the institutionalisation of African traditional medicine and potential collaboration with the biomedical health care system. This was a qualitative study that used in-depth interviews and questionnaires to collect data, which was interpreted using thematic data analysis. A key finding was that participants were mostly influenced by their families with regard to the health care choices – either biomedical or traditional medicine. And that affordability, accessibility and availability are not important factors in health care choices as suggested by literature. Participants also based their decisions on what they believed would help them, either biomedicine or traditional medicine.

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## Table of Contents

<b>DECLARATION</b> .....	<b>I</b>
<b>ABSTRACT</b> .....	<b>II</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>III</b>
<b>LIST OF ABBREVIATIONS</b> .....	<b>V</b>
<b>CHAPTER 1</b> .....	<b>1</b>
1 INTRODUCTION.....	1
1.1 <i>Traditional and biomedicine in South Africa</i> .....	1
1.2 RESEARCH METHODOLOGY .....	3
1.3 <i>Study participants</i> .....	4
1.4 <i>Data collection - Interviews</i> .....	5
1.5 <i>Ethical considerations</i> .....	6
1.6 AN OUTLINE OF THE CHAPTERS .....	7
<b>CHAPTER 2: LITERATURE REVIEW</b> .....	<b>8</b>
2. INTRODUCTION.....	8
2.1. ILLNESS .....	8
2.2. HEALTH.....	10
2.3. TRADITIONAL .....	11
2.4. MEDICAL SYSTEMS.....	11
2.5. AFRICAN TRADITIONAL RELIGION .....	12
2.6. TRADITIONAL MEDICINE.....	13
2.7 LEGITIMIZATION OF THE TRADITIONAL HEALER .....	16
2.8. BIOMEDICINE .....	16
2.9. DECIDING ON MEDICAL SYSTEM/S .....	20
2.10. LEGISLATION AND LEGITIMISATION .....	21
2.11. POSSIBLE INTEGRATION .....	22
2.12. CHALLENGES WITH INTEGRATION .....	24
2.14. <i>Conclusion</i> .....	27
2.15. THEORETICAL FRAMEWORK: SYMBOLIC INTERACTIONISM.....	27
2.16. <i>The medical pluralism paradigm</i> .....	29
<b>CHAPTER 3: DATA ANALYSIS</b> .....	<b>31</b>
3.1. RESULTS.....	31
3.2. DISCUSSION.....	32
3.2.1. <i>Lay definitions of illness</i> .....	33
3.2.2. <i>Illness is not being yourself</i> .....	34
3.2.3. <i>Illness is not being normal</i> .....	35
3.2.4. <i>Illness as an unpleasant feeling</i> .....	35
3.2.5. <i>Illness is not being in control</i> .....	35
3.2.6. <i>Responding to illness</i> .....	36
3.2.10. <i>Reasons for use</i> .....	41
3.3. RELIGIOUS BELIEFS .....	45
3.4. LEVEL OF EDUCATION .....	45
3.5. JACK OF ALL TRADES.....	46
3.6. COLLABORATION .....	47
<b>CONCLUSION</b> .....	<b>49</b>
<b>BIBLIOGRAPHY</b> .....	<b>51</b>
<b>APPENDIX</b> .....	<b>58</b>

## List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ATR	African Traditional Religion
ANC	African National Congress
ATR	African Traditional Religion
AHSPC	Allied Health Service Professions Council
BM	Biomedicine
CAM	Complimentary Alternative Medicine
DoH	Department of Health
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
KZN	KwaZulu Natal
NGO	Non-governmental Organisation
THP	Traditional Health Practitioner
TM	Traditional Medicine
TMH	Traditional Medicine Healer
TMP	Traditional Medicine Practitioner
WHO	World Health Organisation

# Chapter 1

## 1 Introduction

The aim of this study was to find what influences the decision-making process when one is experiencing illness among Rhodes University students and staff members. The research was done using interviews and questionnaires and the results show that depending on what knowledge participants are exposed to they could use both traditional medicine and biomedicine, or only traditional medicine or only biomedicine. This decision was based on what perspective of illness and health they held as some participants limit illness to biological problems, while others include psycho-social issues in their understanding of illness. Participants defined illness as abnormality, loss of control, experiencing pain and having something disturbing your life. The definition was informed by both the traditional and biomedicine health explanations, with one being seen as mystical and the other scientific.

### 1.1 Traditional and biomedicine in South Africa

Traditional medicine is a healing practice that is influenced by different cultural beliefs, it has existed and continues to exist in most communities in the world (Gale, 2014: 806; Hassim & Heywood, 2007: 204; King, 2012: 1176). The World Health Organization (WHO, 2002: 1)) defines traditional medicine as one that “includes diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.” It is a healing system that is holistic, egalitarian, and non-invasive, and according to African belief systems, good health is holistic and extends to the person’s social environment (Cocks & Moller, 2002; Hassim & Heywood, 2007: 204). It is a holistic approach that views a person as more than just a body but rather one that is related to the spiritual world, and therefore relief from any suffering is investigated beyond the living (Cocks & Moller, 2002; Mlisa, 2009). Thus the definition of health from a traditional medicine point of view goes further by emphasising the importance of spiritual health as it is a critical and central aspect (Mlisa, 2009). This holistic approach informs the WHO (1948) definition of health as “a state of complete physical, mental and social well-being and not merely an absence of disease, but a state of complete physical, mental, spiritual and social well-being.”

On the other hand, the biomedical model of health and disease is seen as a collection of medical professionals who use technology, skills and drugs that are employed to cure, treat, and prevent illness by performing physical and psychological treatment (Mbelekani & Coetzee, 2017: 21; Hahn and Kleinman 1983:305). In addition, biomedicine “is usually associated with diseases of the physical body only, and are based on the principles of science, technology, knowledge and clinical analysis developed in Northern America and Western Europe” (Richter, 2003: 7). This approach emerged from the idea that science can be applied to the solution of human problems, an idea developed during the 19<sup>th</sup> century European Enlightenment period (Illich, 1976).

Although the biomedical model dominates health care systems globally, it however has not destroyed the African traditional healing system. It is estimated that 65-80% of the South African population consult African traditional medicine healers for a range of ailments (Cocks & Moller, 2001; de Roubaix. 2016; Faure, 2002; Mbelekani & Coetzee, 2017; Nyika, 2006; Richter,2003; Summerton, 2006). Studies show that many South Africans use both African traditional medicine and the biomedical system. Thus, South Africa has a pluralistic medical system as opposed to a monopolistic health system (Faure, 2003; Mbelekani & Coetzee, 2017; Meissner, 2009). As such, a medical pluralist approach is often taken to investigate the South African medical system (Faure, 2003; Meissner, 2009; Parle & Noble, 2014).

The current study employs a symbolic interactionist approach to understand the subjective interpretations of the use of African traditional medicine and biomedicine. The study may contribute to the existing literature on what informs the contentious choices that individuals make regarding their health problems (Cook, 2009; King, 2012). For example, King (2012: 1171) found that “understandings of disease within South Africa remain deeply contested and expose underlying tensions about how health decision making is shaped by varied perceptions of illness and treatment options”. In addition, researchers have found that biomedical practitioners in South Africa are resistant to collaboration with traditional practitioners due to the discourse on traditional medicine healers (Faure, 2002: 69). Discourse is defined as “ways of constructing knowledge, together with social practices, forms of subjectivity and power relations which inhere in such knowledge and relations between them” (Weedon, 1987: 108). Diamond and Quinby (1988: 108) say that a discourse is not mere conversations and debates, but rather a power strategy that can lead either to domination or to resistance. In the case of the biomedical model, it leads to domination of the African traditional medicine. This has been

based, largely, on the claims that it is scientific and the practitioners are certified and extensively trained (Hassim & Heywood, 2007: 203).

To counter this domination, one of the goals of the African National Congress' (ANC) health policy is to reunite black South Africans with their culture of traditional medicine (Faure, 2002: 63). Efforts have been made to integrate the traditional and biomedical system, as illustrated in the 2008 *Draft National Policy on African Traditional Medicine in South Africa*. A practical example is the utilisation of traditional healers in an effort to curb HIV/AIDS related deaths and illnesses by training them in a biomedical understanding of HIV/AIDS (Faure, 2002: 65). However, there are problems with certifying traditional healers, as 'false' traditional healers could be legalised (Green, 2012: 3). Another problem with the collaboration is that the division of labour that exists within traditional healing system is not acknowledged, and this leads to conflict amongst traditional healers. For example, the *isangoma* (diviner) having to do the work of *inyanga* (herbalist) and *abathandazeli* (faith healers) having to hide behind churches and some practitioners become excluded altogether (King, 2012: 1176; le Roux-Kemp, 2010: 278). The division of labour is supposed to work in that the *sangoma* consults the spirit and the *inyanga* produces the necessary herbs (Hammond-Tooke, 1989). Commodification of traditional medicine is another problem as it transforms traditional practices and impacts the division of labour (Cock & Moller, 2001; Faure, 2002). This can lead to people desperate for traditional health care being taken advantage of by 'false' traditional healers (Hassim & Heywood, 2007: 217).

## 1.2 Research methodology

This study is based on the interpretive philosophy which unlike the positivist paradigm does not believe in the existence of a reality that is out there but rather multiple realities that are socially constructed and which are subject to change. It looks at the way in which people interpret the world (Bryman, 2012: 380). As opposed to having an influence in the external, singular reality that is the basis of the positivist paradigm, interpretivist see people through their interactions as active agents in their understanding of the world (Denzin & Lincoln, 2005). As such, "interpretive researchers seek to investigate how humans perceive and make sense of this world" (Phothongsunan, 2010: 1). The researcher becomes a participant him/her self in the sense that he/she is as much of a meaning maker as the person who is being researched as meanings are being constructed (Bryman, 2012: 381). However, interpretivism has been

criticised because the sample is not representative, and the results can therefore not be generalised (Bryman, 2012). The advantage of this paradigm is that it recognises that life is complex and cannot be reduced to the relations between small variables (Berg & Lune, 2017).

Interpretivist methods are therefore directed at getting qualitative data which is a rich account of observed or verbal data (Denzin & Lincoln, 2005). Therefore, the methods that are employed are often those that enable the participants to speak openly through the use of open-ended research questions (Bryman, 2012). Because the research is aimed at exploring meanings that people attach to the social phenomenon being studied, research based on this paradigm use small samples to collect data, which is critiqued because this means it cannot be generalised or said to be representative of the sample population (Bryman, 2012). However, because the aim is not to generalise but to understand a social situation this is not necessarily a weakness.

A suggested way to strengthen studies that use interpretivism is triangulation (Phothongsunan, 2010). Triangulation is when the researcher uses more than one method to strength the validity of the claims as this would show that more than one thing yielded the same results, meaning that even if someone else did the same study they are highly likely to get the same results (Bryman, 326; Phothongsunan, 2010: 3).

### 1.3 Study participants

Participants were drawn from the Rhodes University student and staff population. Convenience and purposive sampling methods were used to recruit study participants. These are non-probability sampling strategies in which participants are chosen because it is convenient to the research as they are easily accessible, and because they meet the criteria (Berg & Lune, 2017; Biggam, 2011). These methods were appropriate for this study because non-probability sampling does not allow generalisation and this study did not seek to obtain generalizable findings. These are useful strategies when seeking to access information quickly and inexpensively (Berg & Lune, 2017: 28). For this research, Rhodes University isiXhosa or Zulu speaking students and staff members were identified as a convenient group because they are in the same institution as the researcher which saves traveling cost and time. However, Berg and Lune (2017: 37) warn against selecting participants because they are easily available as this can led to the researcher not getting the information that they are seeking.

However, in this study, participants were not simply chosen because they were easily accessible, but because they speak languages that would make translating and making sense easier for the researcher. I am a Xhosa speaker and I understand Zulu, it was therefore easy for participants to express themselves in isiXhosa or isiZulu in a much more detailed manner than they would have had interviews been solely in English. English would not have enabled them to speak about traditional practices that are beyond the scope of this foreign language. The participants were purposefully selected because they have knowledge of traditional medicine, whether it is from using it themselves or mere exposure to those who use it.

Convenience and purposive sampling methods were applicable to this study because the intention was to carry out an exploratory study to understand what informs the health-seeking choices that participants make. This means that the information that is generated cannot be generalised because the sample is not a representation of the Rhodes University population. Furthermore, because the outcome was not meant to be representative, the sample size was small, which allowed for in-depth interviews with each participant, and this increased the chances of detailed responses. A total number of 19 participants were recruited from the students and the staff populations at Rhodes University. They included both female and male participants, and they ranged from 19 years to 57 years of age. The sample included both categories of users and non-users of traditional medicine in order to get diverse views on the perceptions and knowledge of traditional medicine and biomedicine.

#### 1.4 Data collection - Interviews

Various methods of data collection can be used in interpretive studies. Ethnography, case studies, grounded theory, interviews and questionnaires are examples of such methods (Denzin, & Lincoln, 2005). Interviews are seen as key tools in interpretivist research because they enable the participant to discuss their interpretations of the world in which they live, and to express how they regard situations from their own point of view (Cohen, Manion & Morrison, 2001). In these senses the interview is not simply concerned with collecting data about life, it is part of life itself, and its human embeddedness is inescapable (Denzin & Lincoln, 2005). In-depth interviews were used to collect data, and these interviews were conversational in nature (Babbie & Mouton, 2001). The interviews were mainly aimed at obtaining the meanings that participants place on their health-seeking experiences in a manner that was flexible for the participants and the researcher. During the interview, the direction of the conversation can be

changed by a response or by a probing question from the researcher to further investigate a point said by the interviewee (Babbie & Mouton, 2001: 291). This may be disadvantageous in that they might end up drifting into a different direction at which point the researcher has to take control and lead it back to the original topic of discussion (Babbie & Mouton, 2001). In this study a semi-structured interview was used (see appended interview schedule), it is defined as a flexible interview where the researcher has a set of prepared questions which he/she is not required to follow as they appear in order or wording (Berg & Lune, 2017: 68). In the case of this research, this was appropriate because the participants are not first language English speakers and some questions needed to be rephrased and translated in isiXhosa or isiZulu for better understanding. The interviews were conducted with each participant in her/his residence room on campus or in her/his office. They were asked open-ended questions that allowed them to give detailed responses because the answers are not predetermined and the interviewee has the freedom to explain themselves. The interviews were recorded with the informed consent of the participant, and later transcribed and analysed.

In addition to the interviews, questionnaires were also distributed to participants (see appended questionnaire). Questionnaires can be defined as a data collection tool which is quantitative in nature because it does not give in-depth information, but it can also be used in qualitative studies (Bryman, 2012). This method is advantageous because it can be self-administered which gives the participant time to process the information and actually understand the questions before answering them without the pressure from the researcher (Bryman, 2012). Questionnaires can also be disadvantageous because participants might choose not to answer the questionnaire or leave some things out sometimes because they do not understand what you were trying to ask (Bryman, 2012). Another disadvantage is that their responses are restricted, and some people may find that the options that are presented do not fully capture what they want to say (Bryman, 2012). Data was analysed using thematic analysis, which is a method of analysing qualitative data that is done through identifying patterns in data (Braun & Clarke, 2006).

### 1.5 Ethical considerations

To ensure that a rigorous and fair study was carried out, the purpose and the aim of the research was explained to research participants before the start of the interview. Participants were also assured that their names will be changed in the research report. This allowed them to give

informed consent, however this may have influenced the participants' responses because some just wanted to appear correct instead of simply sharing their health-seeking experiences.

## 1.6 An outline of the chapters

Chapter one provides an introduction to the study and a brief description of biomedicine and traditional medicine, with a specific focus on South Africa. It also states the methodology used in the study. The second chapter provides a literature review and the theoretical framework. Chapter three provides a description and analysis of the study findings and it provides a detailed account of the data collection process, what kind of information was collected and what patterns were found in the data. The fifth chapter is an interpretation and analysis of the data, and a conclusion to the study.

## Chapter 2: Literature Review

### 2. Introduction

South Africa has a pluralistic healthcare system however, the biomedical model dominates the indigenous and alternative healing systems. This dominance can be attributed to the state whose legislation and policies on health and healthcare drives the discourse on medicine in the country. Sobiecki (2014: 1) notes that “traditional African medicine often carries with it a perception and stigma of being irrational and ungrounded in scientific method in academia”, and as such, it is always rendered untrustworthy and as posing a danger to those who use it. On the other hand, biomedicine is generally accepted due to its scientifically based knowledge and practice. Regardless of the negativity attributed to traditional medicine most black South Africans still use indigenous healing methods (Cocks and Dold, 2000: 1506). It is for this reason that the WHO (2002) suggests that an integrated medical system is ideal as traditional healers could be monitored and regulated, so that their methods and medicine is tested. This is also a strategy to reduce the mortality and morbidity rates in developing countries (Mbhatha, 2012: 129; Meissner, 2009: 6). South Africa has since adopted the WHO initiative as is reflected in the draft policy for traditional medicine (Department of Health, 2008).

This chapter starts with definitions of key concepts, and this is followed by a discussion on models of medical systems - namely, tolerant, inclusive, integrative, exclusive/monopolistic and pluralistic systems. Then a discussion on traditional medicine and biomedicine, and concludes with a review of the South African legislation and legitimization of traditional medicine.

### 2.1. Illness

Senior and Viveash (1998: 20) argued that there is no universal definition of illness. However, in most western societies, the medical model’s definition of illness is the one that is dominant. Cultural definitions of illness however often differ from those of the medical model, in fact even within biomedicine there are competing explanations of illness. Lewis (1976 in Senior and Viveash, 1998: 20) in an ethnographic study that he conducted in New Guinea found that the definition of illness as something that is physical or psychological which medical doctors adopt was not applicable to the Gnaou people of New Guinea, as they understood illness as any negativity that an individual is experiencing in their life.

This same phenomenon is evident with the pluralistic medical system in South Africa where the dominant understanding of illness is that of the medical model, and there are indigenous healing systems which are holistic (considers physical, spiritual, emotional components when establishing root of illness) in their approach in that health and illness is extended beyond one's body (Deacon *et al.*, 2004). Flint (2008: 19) argues that multiculturalism has led to different understanding of symptoms which inevitably results in different treatment. His historical study of KZN found discrepancies between the interpretations of the body in the period 1820-1948, and he concluded that not only are the concepts of illness, health, the body and wellness different due to multiculturalism, but that they are also time specific (Flint, 2008: 19). He also noted how in biomedicine the body is conceptualised in a fairly mechanistic manner, and that in Ayurveda (Indian traditional medicine) the body is conceptualised as being composed of five constituent parts (*mahābūta*), seven body substances (*dhātu*) and three regulating qualities (*doṣa*) (Flint, 2008: 19).

Studies show that patients tend to consult people with whom they share cultural values, understanding of the body and etiology of illness (Flint, 2008; Meneses, 2008; Mutwa, 1996). However, some people are purely driven by what they believe to be more effective or it is cheaper and available, or if the traditional treatment had failed (Chavunduka, 1994). Some however may be using it unknowingly as they merely accept what they are given and others are driven to their choice by culture-bound illnesses (Meneses, 2008: 364). Traditional healers are usually consulted for illnesses perceived as traditional illnesses, which are said to be emotionally taxing as the patient's body is attacked by a spirit (Mutwa, 1996). The traditional healer then plays a dual role of divining and curing where they have to find and treat the physical symptoms of the sickness. This treatment is often concluded with a cleansing ceremony to restore balance in the patient's life by removing all impurities, which is also meant to prevent the patient from experiencing the same or a similar illness (Chavunduka, 1994: 81; Meneses, 2008: 364; Urbasch, 2002: 12).

Although there are culture-bound traditional medicine and illnesses, there are some that cross the boundaries of culture. For example, Flint (2008) found that an Indian in KZN had become an *ithwasa* (traditional healer trainee) which is predominantly considered to be a Nguni (a group of black South Africans) practice in South Africa (Flint, 2008: 20). This would support Hahn's (1995) argument that that no illness is purely a result of culture and rather says that it is merely a matter of interpretation. Hahn (1995: 41) states the term 'culture-bound syndromes

is a conceptual mistake' as illness can be caused by many factors which cannot be simply reduced to culture. He argues that the concept is reductionist as no phenomenon has a single explanation, and that culture-bound syndrome cannot occur without the cultural aspect. This is based on a perspective that traditional medicine which is largely informed by religion, comes with a way of seeing and interpreting illness by considering spirits and ancestors in the explanation of illness. For example, *thwasa* illness (an illness due to a calling to be a healer) could simply be seen as a case of schizophrenia, it can be interpreted as psychosis because of the similarities that they share (Kubeka, 2016). As such, outside the cultural scope of traditional healers, this illness could easily be misdiagnosed, a situation which has evident consequences to the person (Mutwa, 1996; Rankopo, 1996). This means that traditional healing methods should be studied in their own context, and the only cure is for the person with *thwasa* illness is to obey the ancestors who convey their wishes through dreams or visions (Mndende, 2006: 51).

Besides the definitions of illness that are given by different cultures, illness is also a subjective notion that depends on people's own interpretation of their mental and physical condition and what symptoms they count as an illness (Senior & Viveash, 1998: 8). This means that there is no single, completely agreed upon definition that everyone accepts. As such, although one person might report decreased physical energy to a doctor, someone else might not necessarily consider that a symptom of illness that they need to report to the doctor (Senior & Viveash, 1998: 10). It must be pointed out that biomedicine, classification of illness is often the job of a doctor (Senior & Viveash, 1998: 10).

## 2.2. Health

Health, according to WHO (1948), is a state of complete physical, mental and social well-being and not merely an absence of disease. This definition covers a health in a holistic manner which, in South Africa, is more apparent in what is viewed as the alternative and contemporary medical system. Because in as much as other issues are considered in biomedicine, its treatment is focused on the body and has no social and spiritual aspect of health (Senior & Viveash, 1998: 10). Meneses (2008: 358-359) examines how various cultures in Africa, and elsewhere in the world, share a broad understanding of health where having good health is equated with having a good successful life, and where one has good relationships with both the living and the dead, which is free of bad luck, and where both one's family and property is protected.

### 2.3. Traditional

For the purpose of this research traditional is used to refer to African indigenous health-related components such as treatment remedies, varied healers, and perspectives. This understanding of traditional excludes alternative and complementary healing systems that are not African, which includes Chinese and Indian traditional medicine, as well as the respective practitioners in these systems. Traditional medicine practitioners or healers (TMPs or TMHs) in this study refer to black, African healers, diviners, midwives, and prophets or faith healers. Traditional refers to indigenous South African medicine that comprises herbs and animal artefacts used by black African communities, and these exclude those which have been imported from other countries (Cock & Dold, 2000). It is worth acknowledging that within Africa, and South Africa in particular, there is a large variation of traditional medicine. Many of these share the same beliefs about health and illness, and how to achieve and maintain health (Chavunduka, 1994).

### 2.4. Medical systems

Most contemporary societies have pluralistic medical health systems. These can be categorised into one of three systems - the tolerant system, the inclusive system and integrative system (Gqaleni *et al.*, 2007; Mbatha *et al.*, 2012). First, the tolerant system is described as one in which “national healthcare is based entirely on allopathic medicine, but certain traditional medicine practices are tolerated by law” as is the case in South Africa (Mbatha *et al.*, 2012: 129). Second, the inclusive system is one where traditional medicine is recognised but with no full integration into the mainstream healthcare. Third, the integrative system is one in which there is full incorporation of all existing healing systems in a country, for example in China, Vietnam, and the Democratic People’s Republic of Korea, Republic of Korea (Meissner, 2009: 35). There is no integrative system in any African country. Ingle (2009) adds a fourth category - the exclusive/monopolistic system, which is the complete marginalisation of any system that is outside of what the mainstream western healthcare system recognises. However, Ingle (2009) recognises that the monopolistic system works on a continuum from exclusive to integration.

As stated above, South Africa has a pluralistic healthcare system where traditional medicine is merely tolerated. Gale (2014: 810) notes that “medical pluralism draws attention to the diversity of practices in a health system and can be distinguished from medical monism where there would be unity of practice or medical dualism where there would be a binary opposition

of practices”. However, medical pluralism is not equal representation of all systems as biomedicine remains dominant. This is not unique to South Africa, it is common around the world and “it usually involves a modern biomedical health care system as a dominant player in coexistence with *alternative medicine*” (Meissner, 2009: 18). The WHO (1993: 5) defines alternative medicine as “all forms of health care provision which usually lie outside the official health care sector”, and this includes African traditional medicine.

Cocks and Dold (2000: 1512) in a study titled *The role of ‘African Chemist’ in the health care system of the Eastern Cape province of South Africa* found that African traditional medicine is sold alongside other alternative medicines such as Dutch, Chinese and Indian medicine. This pluralism in herbal medicine extends to traditional health practitioners as there are some similarities between the South African traditional practices and the neighbouring countries (Meneses, 2008; Chavunduka, 1994; Xaba, 2007; Xaba, 2002). For example, the Xhosa and the Zulu of South Africa, the Shangani of Mozambique, and the Shona of Zimbabwe have similar names for traditional healers who perform similar roles and who all go through the same rite of passage as they are initiated into the traditional healing practice (Rankopo, 1996; Xaba, 2007; Chavunduka, 1994; Meneses, 2008). The ritual of *ukuthwasa* (traditional healer training and initiation) takes the same process in most southern African countries such as South Africa, Botswana, Mozambique and Zimbabwe. As Mutwa (1996) and others note there are continuous parallels in these countries’ myths, rituals, and customs, and similar cosmologies (Chavunduka, 1994; de Roubaix, 2016; Mndende, 2009). This is why it is widely accepted that “sub-Saharan Africans have one common belief system” (Mndende, 2009: 27).

## 2.5. African Traditional Religion

African traditional religion (ATR) existed long before Christianity and Islam were introduced in Africa. Over the centuries there has been various understandings and side-linings of African religion by colonialists, but like traditional medicine, it is slowly being recognised, especially its role in health and decolonialization (de Roubaix, 2016). ATR can be defined as the beliefs and practices which are shared by most sub-Saharan Africans, and it is handed down from generation to generation (de Roubaix, 2016). It is characterised by the belief in God, the creator, ancestors, and the performance of rituals (Mndende, 2009). ATR is orally passed down, unlike recorded Islamic and Christianity texts, and this fails to capture the growth and change in ATR. As Dopamu (1991 in Mndende, 2009: 111) explain that ATR is “a religion originated from the

peoples' environment and on their soil. It is neither preached to them nor imported by them. Africans are not converted into it. Each person is born into it, lives it, practices it, and it is proud to make it his own." Most ATR practices include holistic healing aspects as discussed earlier.

## 2.6. Traditional medicine

As discussed earlier, traditional medicine is a healing system that is culturally-based, which has existed and continues to exist among the indigenous people (Deacon, Phillips, and van Heyningen, 2004; Gale, 2014: 806; Hassim & Heywood, 2007: 204; King, 2012: 1176). TM is a healing system that is said to precede what we now consider to be the dominant medical system in South Africa (Hassim & Heywood, 2007: 204). Its existence dates back to before the colonialization of African countries and the voyage of missionaries as they encultured people into Christianity. It is a system in which health is related to the environment, social relations, the economy, superior beings and the dead. Xaba (2007) notes that it is a system that is founded on three fundamental features – it is holistic, it is an egalitarian practice, and it is non-invasive. The rhetoric of TM is often one that is invested in the acts of an external party that is often seen as the source of the ailment or misfortune (Faure, 2002: 3; Xaba, 2002: 23).

The above has not only led to witch hunts but also to traditional healers themselves being labelled as witch doctors or sorcerers. The rhetoric of witchcraft is said to have come about with the growing need of traditional healers were false healers saw an opportunity to capitalise on the vulnerability of the black people (Faure, 2002: 3; Xaba, 2002: 23). These false healers use human body parts to create what they regard as strong medicine, and these practices validate the negative biomedical assumptions on TM and unfortunately, gives a bad name to TM practitioners (Xaba, 2002). Therefore, there is a need to distinguish between the forms of medicine and practices, as well as practitioners that exist in the traditional healing system (Xaba, 2002). For example, there is TM that is meant to cause harm and misfortune, which is referred to as *ubuthakathi* (Flint, 2008: 59). Then there are *izangoma* or *inyanga* who use herbs to cure ailments and other states of being unwell that patients consult on. Studies have found that when traditional healers are trained to become healers they are also shown the toxic herbs which can be used to harm others (Chavunduka, 1994; Xaba, 2002). However, most traditional healers aim to heal their patients, and few cater to the 'darkside' of TM (Xaba, 2002).

Meneses's (2009) study looked at how in the creation of knowledge about health and medicine, the 'othered' are at a disadvantage as they tend to come second to biomedicine which is seen as 'official knowledge' and legitimised by the state. The primary objective of Meneses's (2009) study was to evaluate the perceptions that are held about the various medical systems that exist in Mozambique. In-depth interviews were held with practitioners, patients, and government organisations and NGOs who are involved in health policy and health care in Mozambique. The study concluded that there is a need to reconsider the place and role of medicine in Mozambique so that all the voices of the various actors involved are heard. TM is often reduced to a practice with local applicability/relevance and as the alternative to biomedicine. As Meneses (2009) argues that both in the past and the present, traditional medicine is associated with localised, native, or indigenous knowledge. The western understanding of TM is often so simplistic that it is reduced to midwifery and healing. It does not take into account the historical, social-cultural, economic, political and spiritual aspects that underline the concept of health.

It is important to note that there are different specialisations in traditional medicine, for example, among the Xhosa and Zulu people, there are *amaqhirha /inyanga* (healer), *izangoma* (diviner), *amaxwele* (herbalists), *ababekisi* (traditional birth attendants) and *abathandazeli* (faith healers). A *qhirha* (healer) uses *ngoma* (an indigenous ritual of healing, dance, rhythm and rhyme in the southern-African region) to get in contact with their ancestors or the patient's ancestors to find the source of the ailment and the type of treatment (Chavunduka, 1994; Mutwa, 1996). This is usually followed by a cleansing ritual so that the patient does not suffer from the same illness again (Hammond-Tooke, 1989; King, 2012: 1176; le Roux-Kemp, 2010: 278; Meneses, 2008; Sindiga, 1995). The *Inyanga/ixwele* (herbalist) can work in conjunction with *sangoma/igqirha* (healer) by sourcing out the plant or animal parts needed to cure specific illnesses and misfortunes (Xaba, 2007: 321) Herbalists can also work on their own, providing medicine to restore physical, spiritual and social health. Abathandazeli (faith healers) as the name suggest, use religion to diagnose and cure (Xaba, 2007: 321). They can either rely solely on prayer and God or they could use a combination of religion and ancestors. Ababekisi (traditional birth attendants) deal with pre-natal, childbirth and post-natal care (Rankopo, 1996). In attending to pregnant women, ababekisi who have access to modern medicine often use it in addition to traditional medicine (Faure, 2002; Hoyler, 2016).

A further distinction is made between the various forms of TM. There are those that consist of indigenous herbs and knowledge, those that are a mixture of different Africa traditions, and

finally others such as the Chinese or Indian medicine (Cock & Moller, 2001). These are namely: herbal, indigenous/traditional, and indigenised medicine (Cock and Moller, 2001: 2). Herbal medicine refers to medicine derived from plants originating in and out of Africa. Indigenous medicine refers to medicine derived from plants and animals. Indigenised medicine refers to “modern medicines and medicines adopted from other cultures which have been incorporated into the array of indigenous medicines” (Cock & Moller, 2001: 2). Researchers often ask the question: what is it about indigenous medicine and practice that makes it ‘traditional’? (Flint, 2008: 1). For example, what is ‘traditional’ about TM healers, who have set-up herbal shops similar to modern pharmacies, and who do not throw bones when dispensing medicine (Flint, 2008: 1). Cock and Moller (2001) observed similar herbal shops in King Williams Town and Peddie in the Eastern Cape, which shows that traditional medicine is evolving and modernising. As noted above, *ababelekisi* (traditional birth attendants) who have access to western medicine use it on their patients.

Another aspect that makes TM ‘traditional’ is that traditional healers are usually called to become healers by their ancestors (Mndende, 2006). The calling is usually for diviners and it is said to be from dead spiritual beings who were also healers when they were alive (Rankopo, 1996: 20). This calling normally manifests itself with symptoms that imply illness and suffering that cannot be cured by biomedicine (Deacon, 2004; Rankopo, 1996: 20-22). Buhrmann (1981: 877 in Urbasch, 2002: 14) defined *ukuthwasa* (the period of initiation that one undergoes in order to become a sangoma/healer) as “the emergence of new aspects of the personality through the acceptance and integration of unconscious material.” Most importantly, the calling is often presented through persistent dreams and visions which signify the calling of the ancestor (Mndende, 2006). This process of calling usually takes a period of months, sometimes years, and during this time, the *thwasa/mkwetha* (initiate/trainee) goes through a lot of rituals (Chavunduka, 1994). The individual is removed from his/her community into a sacred environment, either a home of a great healer which he/she is directed to by ancestors or a specific location that is specific to the person’s future qualification as a healer (Chavunduka, 1994; Chang, 2002).

Sacrifices to the ancestors are also made at this time, and the novice healer is expected to pay a fee to the qualified healer who is initiating him/her (Meneses, 2008: 363). The purpose of this ritual is not just to cure the person from their illness but mostly to strengthen them and teach them the different plants that can be used as medicine and connect with their ancestors (Meneses, 2008). This contradicts the claim by biomedical practitioners that traditional healers

are not trained to practice medicine (Meneses, 2008). Their training is different, and away from the confines of a university/college building. As one traditional healer in a study conducted in Mozambique pointed out that although they may be illiterate and do not document their knowledge on paper, they are well educated in TM, and that they know things that no university education could teach them (Meneses, 2007). In addition, many traditional healers were exposed to herbs and healing practices when they were young, they acted as assistances to their parents/grandparents or other relatives who were traditional healers or just knowledgeable about medicinal plants and animal parts (Chuvunduka, 1994; Deacon et al, 2004; Mlisa, 2009ro; Mutwa, 1996). However, this exposure is often not enough, particularly for diviners, who as noted above need *ukuthwasa* initiation rituals. Deacon *et al.* (2004) further note that even though there are commonly known herbs which are used as home remedies, there are some which were kept secret and passed down in the family.

## 2.7 Legitimization of the traditional healer

The community monitors the new initiate, and is also overseen by other trained healers, and they exchange ideas and medicines, and this helps to validate the qualification of the new member (Chavunduka, 1994: 2). As WHO (2001) note that in order for one to be a traditional medicine practitioner (TMP), they would have to be known within the community by both the people and other TMPs. They would need to have had practical training under another healer for no less than a year to five years and be registered with a Traditional Healers' Organisation (WHO, 2001). Traditional healers are continuously legitimised through this system of surveillance and through their work, and their reputation and success depend on this process (Chavunduka, 1994: 2). This includes work outside the healing process, for example, a renowned traditional healer helped a taxi owner who had been a victim of crime recover his property, this was after the South African police had failed to solve his case (Xaba, 2002: 23). Regardless of the training, legitimacy and practice, traditional medicine is still marginalised as the official healthcare in South Africa is biomedicine.

## 2.8. Biomedicine

The biomedical approach which is also known as the medical model gained prominence in the nineteenth century and has since been dominant (Armstrong, 2000; Illich, 1976). Within the medical model, illness is seen as something which is caused by a virus, bacteria, genetics or an accident and has no spiritual aspect to it (Senior, 1998: 10). This is also known as the doctrine

of specific aetiology or the germ theory where each sick part in the body is believed to have a biological cause which has to be identified to treat the affected area (Armstrong, 2000; Dubos, 1992). In other words, illness is not result of evil spirit or curses but rather as a result of identifiable and classifiable causes with observable symptoms (Senior & Viveash, 1998: 10). From ancient Greece to today, the role of medicine has been mainly to manage diseases and disability, manage pain and reduce infant mortality (Bradby, 2008). In addition to this relatively stable role of medicine is the relationship of the patient to the practitioner which is structured in a way that the patient has no negotiating power over the treatment or the diagnosis and as such, it is an objective system, which Foucault related to the power of discourse (Senior & Viveash, 1998: 13). The patient plays a passive role as practitioners depend mostly on technological medical interventions to find the problem, limiting the patient's role to telling them the physical symptoms that they (patient) are experiencing and taking the prescribed treatment (Armstrong, 2000; Roux-Kemp, 2010).

Before biomedicine gained its prominence in the nineteenth century, medicine was not practiced by medical professionals only as practitioners included physicians, faith healers, and women, and treatment was dependent on the financial resources of the ill person (Bradby, 2008). Practitioners practiced bedside medicine in the homes of the patients, and the role was to limited to observation and interpretation of illness as experimenting on human bodies to understand illness and come up with treatment was seen as blasphemous, deviant, and immoral (Bradby, 2008). During the enlightenment period, hospitals developed and were funded privately by the bourgeoisie and charities, as they were initially for the poor who could not afford home visits (Bradby, 2008). In addition, scientific experiments on the human body placed medical professionals in a place of prominence as they supposedly held the truth about health and illness (Senior & Vivesh, 1998). Michel Foucault saw this as being a result of the dominance of the medical discourse as he believed that this language or discourse had power and as such, the new-found ability to describe the body, classify and treat or cure illnesses and give diseases in the human body identifiable terms, gave them status (Senior & Viveash, 1998: 13). Medical dominance was also a result of the formal training of medical doctors, and the registration to the General Medical Council, and the unregistered practitioners were criminalised (Senior & Vivesh, 1998).

This is a medical system that is described as being narrow in its perspective as it treats and concerns itself only with the body. It employs medical technologies and trained personal to

prevent and treat illnesses. This model is one of many western techniques that were introduced during the times of colonialism where the mission was conquest. This according to Xaba (2007) was achieved through the use of the Trojan horse which is made up Christianity, missionary education, and the role of state and medical establishments. These were used to manipulate black people into abandoning their beliefs which was considered to be a step towards developing them. This was set up in such a way that any good education that a black person got was in a missionary school where traditional healers were considered superstitious and evil (Xaba, 2007). The state was instrumental in stipulating what was considered appropriate for mainstream medicine and what was not. The practice of traditional medicine was prohibited during colonialism and apartheid, forcing people to use biomedicine (Xaba, 2007). However, due to the limited human resources within the medical system, traditional medicine was allowed to continue functioning within their geographical locations to make up for what conventional medicine could not provide (Xaba, 2007).

Biomedicine is seen as a collection of medical professionals who use technology, skills and drugs that are employed to cure, treat, and prevent illness by performing physical, psychological treatment (Mbelekani & Coetzee, 2017: 21; Hahn and Kleinman 1983:305). Biomedicine “is usually associated with diseases of the physical body only, and are based on the principles of science, technology, knowledge and clinical analysis developed in Northern America and Western Europe” (Richter, 2003: 7). This approach emerged from the idea that science can be applied as a solution to human problems – an idea developed during the 19<sup>th</sup> century European Enlightenment period (Illich, 1976). According to Foucault (1980), the medical discourse and the medical professionals were the cause of the demise of the health system that dominated before biomedicine (Xaba, 2007). Biomedicine is said to have emerged during the nineteenth century parallel to as opposed to the healing system which was grounded on traditional (indigenous or traditionalised local) knowledges (Sinior & Viveash, 1997). It does not recognise any diagnosis that is made outside of biomedicine simply because it is different and without no equal power to detect illness. The dominance of biomedicine is recognised by the state which gives it legitimacy and status above the other existing medical systems. Medical systems which were once highly regarded no longer have as much influence as their form of knowledge is seen as non-sense, superstitious, metaphysical and mere belief and speculative (Urbach, 2002).

A discourse can be defined as “ways of constructing knowledge, together with social practices, forms of subjectivity and power relations which inhere in such knowledge and relations between them.” (Weedon, 1987: 108). Diamond and Quinby (1988: 108) say that a discourse is not mere conversations and debates, but rather a power strategy that can either lead to domination or resistance. In the case of biomedicine, it has been the former. This has largely been based on the claims that it is scientific and the professionals are certified and trained (Hassim & Heywood, 2007: 203). Therefore, the judicial medical decision by state that marginalised and criminalised traditional medicine, while legalising biomedicine is how it became dominant (Meneses, 2017). The state defines the official/non-official dichotomy, which establishes by law-among the wide variety of therapeutic forms, which is a more or less explicit distinction between what is legal and what is illicit, if not illegal (Meneses, 2007: 335). Everything recognised as official medicine is supported by the state, and medicine not recognised as official is tolerated, but frequently ignored (Meneses, 2007: 355). Outside of state recognition, biomedicine is said to be the dominant profession because of the autonomy it has over its work, the body that regulates its ethics and practice and the scientific knowledge and training that informs the profession (Wolinsky, 1988).

Doctors do not have authority just over their own work, as this authority has been extended to the medicalization of life in general (Illich, 1976). In the labour market doctors have the authority to temporarily relieve an employee of their duties when they are ill by providing them with a doctor’s certificate which they can present to their employer to ensure that they receive paid leave (Mbhatha, *et al.*, 2012: 130; Sinior & Viveash, 1998). This authority to issue medical certificates is not extended to traditional healers. This creates a problem for some employees as their constitutional right to consult whomever they please are restricted (Mbhatha, *et al.*, 2012: 131). This is one of the reasons why the motion to include traditional healthcare practitioners into primary healthcare was proposed. When this was signed in 2008, all persons that are allowed to treat and diagnose people that are registered with a professional council were permitted to issue sick certificates, this includes those registered with the Health Professions Council of South Africa (HPCSA) and Allied Health Service Professions Council (AHSPC), including Chinese and Indian traditional medicine, but not African Traditional health practitioners (THPs), despite being the largest service provider (Mbhatha, *et al.*, 2012: 131). This has resulted in the Basic Conditions of Employment Act (BCEA) not recognising sick certificates from African healers. However, some employers accommodate African cultural beliefs and accept sick notes issued by THPs (Mbhatha *et al.*, 2012). With the

registration of African traditional healers being able to and required to register as per The 2007 Traditional Health Practitioners Act of South Africa requires registration for African traditional healers to register, and this means that THPs who are registered can issue sick notes.

### 2.9. Deciding on medical system/s

Rankopo (1996:4), in an article titled *The influence of the traditional health practices on human development: implications for human service delivery* argued that traditional healers could be instrumental in improving healthcare services. He does this by looking at various case studies in Botswana which show how influential traditional health practices are in the way people behaved. He reported that myths and taboos are the corner stone in behaviour regulation and this is beneficial because it prevented them from being predisposed to ill health and deviating or contesting these myths is punishable (can bring a curse) within African communities. Rankopo (1996: 14) found that despite the presence of biomedical facilities, women chose to give birth at home because of the continuous holistic care and advice provided by traditional midwives. Literature shows that the predominant use of traditional medicine is due either to the psychological and social roles of traditional health-care providers or to cultural health beliefs. Hoyer et al (2016:2) argued that “While some biomedical services are available in these impoverished communities, many Maya utilise traditional medicine as a significant, if not primary, source of health care. Previous studies illustrate this, arguing that the predominant use of traditional medicine is due either to the psychological and social roles of traditional health-care providers or to cultural health beliefs (Coreil, Augustin, Halsey, & Holt, 1994; Feyisetan, Asa, & Ebigbola, 1997; Kleinman, 1980)”.

In addition to the above, TM is said to be non-invasive, egalitarian, and holistic because THPs do not merely prescribe medicine to people but they impart TM knowledge to patients (Xaba, 2002). The herbs and animals that are used as medicine is also readily available in nature, which makes TM more accessible, particularly with home remedies (Xaba, 2002). Therefore, THPs are said to be a preferred medical option because they are trusted and respected in their communities, their practice is culturally embedded, they usually live close to their patients, and this is less expensive than biomedicine (De Roubaix, 2016: 160)

Nchinda (1976:134) in Meissner (2009) maintains that traditional African medical systems survive because they satisfy four basic user requirements: accessibility, availability, acceptability and dependability. Even where biomedical health care facilities are physically

present, actual utilisation patterns indicate that biomedicine is not preferred for many illnesses nor for common events such as childbirth (Meissner, 2009: 34-35). As the earlier discussed study on women in Botswana show women prefer home birth by traditional midwives instead of going to a hospital.

Another reason that was given for people consulting TM is the belief that there are illnesses that cannot be cured or treated using biomedicine (Mutwa, 1996). In some cases, people trust and use TM after failed biomedical treatment (Foko, 1989; Fredricks et al., 1986; Morgan, 1983; Schapera, 1955 in Rankopo, 1996: 17). In other cases, it is due to the fact that some illnesses are believed to be caused by gods, ancestors, witchcraft and curses (Chavunduka, 1994). A believe in such causality cannot be handled within the scientifically-based BM. TM in such instances act as a preventative tool because once the cause has been identified and the illness treated, the person receives a purification ceremony which will prevent such illnesses from attacking them again (Chavunduka, 1994).

#### 2.10. Legislation and legitimisation

Historically, African THPs have gone through many trials, figuratively and literally. This is due to the fact that the apartheid state informed medical discourse through discriminatory laws such as the South African Witchcraft Suppression Act 3 of 1957 and amended by the Witchcraft Suppression Amendment Act 50 of 1970 (le Roux-Kemp, 2010: 277). These Acts hindered the way in which traditional medicine was practiced because in indigenous cosmology witchcraft is crucial in the explanations of the causes of illness, and the treatment (Xaba, 2002). Mndende (2006) Besides legislative means, such as Act 3 of 1957 and Act 50 of 1970, to suppress TM other aspects of traditional practices of indigenous people were suppressed through converting Africans to Christianity (Mndende, 2006). Traditional African Religion was also questioned and deemed primitive and blasphemous, and based on witchcraft (Mndende, 2006).

All the attempts by the colonial and apartheid states to suppress or eliminate TM failed to the extent that the ANC led government is trying to integrate it and biomedicine (DoH, 2008: 8). Integration of TM into allopathic medicine is on the recommendation of the WHO (2002), who argue that TM can be the mainstay of healthcare in rural and remote areas. In line with the WHO (2002) recommendation, South Africa drew up the Draft National Policy on African Traditional Medicine in South Africa, which is designed to provide a framework for the

institutionalisation of African Traditional Medicine in the South African healthcare system (DoH, 2008). This policy seeks to set the guideline on how to incorporate the traditional African medical system into the dominant medical system.

The goal of institutionalisation according to the draft policy is to create an accessible and affordable integrated healthcare system. In 2006, a directorate of traditional medicine was established to spearhead initiatives to institutionalise traditional medicine (DoH, 2008). It is tasked with the licencing of traditional healers, the listing of African traditional medicine and its uses; to form regulations on harvesting of herbs, and to establish an ethics committee for African traditional medicine (DoH, 2008). Furthermore, funding was made available by the government for research and development on African traditional medicine.

### 2.11. Possible integration

In 1994, the African National Congress's (ANC's) stated that traditional medicine was going to be officially recognised and integrated into the health system so that South African citizens could enjoy the Constitutional right to healthcare of their choice (Le Roux-kemp, 2010; Leclere-Madlala, 2002: 63; Mbhatha, *et al.*, 2012: 130). The ANC further stated that legislation will be changed to ensure the control of traditional healing practices. So far, South Africa has not progressed as intended in 1994, because TM is still perceived as being unsafe and ineffective, lack of resources, not enough human capacity, funding, regulation capacity and inability to mass produce (Re Roubaix, 2016). The promises of democracy, according to Mndende (2009), do not afford indigenous people who practice African religion the freedom and equality that we supposedly have. What has changed is that, unlike when South Africa was under colonial rule, it is now the black elite and African Christian theologians who are actively suppressing their own heritage (Mndende, 2009). The first of the black Africans to suppress TM was a Xhosa man called Ntsikana, who was an early Christian convert and was said to be a prophet. He stopped believing in ancestors, refused to use TM and other African cultural practices such as polygamy. He called those who still practiced TM and cultural practices as heathens and sinners. He was most likely used by the missionaries to get the Xhosas to neglect their African traditional religion. He told the Xhosas that about a vision he had of the coming of a book and money (Mndende, 2009). This is the same way of thinking that some present-day African Christians view TM and other cultural practices.

There are many advocates for the integration of TM into biomedicine as they suggest that this would be instrumental in improving health services (Ingle, 2009). When THPs are fully embraced by the health system, it could help free up resources within the under-staffed biomedical sector. However, “de facto integration poses formidable institutional challenges and it is not clear that South Africa has reached the stage where it has the implementation wherewithal to introduce such a system” (Ingle, 2009:54). Ingle (2009) further argues that this slow progress is what South Africa needs, as it should strive to mature the inclusive system before embarking on full integration. He came to this conclusion by weighing the challenges and successes in countries such as China which has an integrated health system. He also reviewed the progress made on integration of TM into biomedicine in other African countries, namely Zimbabwe, Nigeria, and Ghana. Many developing countries still have an inclusive medical system. This often comes after a time of tolerance and therefore some level of legality to acknowledge its inclusion. However, there is never any clarity in the terms of the integration (Ingle, 2009: 55).

The passing of the Traditional Health Practitioners Act (THPA) in 2004 brought the status of the South African medical system to a de jure phase of inclusiveness (Ingle, 2009). Although legally TMPs are recognised, they are not necessarily accepted as an integral part of the mainstream health services. As Muller and Steyn (1999) argue there is already some level of working together between indigenous medical practitioners and the biomedical practitioners. However, there are still some issues that are keeping South African from enjoying a fully incorporated healthcare system. In the interviews that they conducted to establish the views held by practitioners in the traditional medical sphere it was concluded that various factors stood in the way of the co-operation between traditional healers and their biomedical practitioner counterpart. These include “differences in perceptions of disease causation, traditional healers' reluctance to expose their cultural heritage and to betray the trust of their ancestors, communication differences such as traditional healers' inability to translate their cultural heritage into words, and the consequences that professionalization might have for them.” (Muller & Steyn, 1999: 143).

Some of the reasons for the limited co-operation can be seen in the way South Africa has integrated some programs on HIV eradication with traditional healers, who were trained in the biomedical perspective of HIV/AIDS (Faure, 2002: 58). This is minimal integration when compared to China, where traditional Chinese medicine is taught in medical schools (Faure,

2002). This means that there is capital motivation behind the collaboration of traditional and biomedicine. In addition, integration can only work if there has been prior a degree of acceptance, and therefore the challenge of integration in South Africa is that TM has no way of regulating and punishing for malpractice (Faure, 2002).

However, some regulation has been achieved, for example the 2005 Children Bill, which protect young men from botched circumcision which has resulted in a number of deaths and amputations in hospital, especially in the Eastern Cape, South Africa (Vincent, 2008: 77). Irrespective of these prohibitions, patients still seek traditional medicine as it is more accessible, and illness as well as treatment are understood in a traditional perspective (Schierenbeck, Johansson, Andersson, Krantz & Ntaganira, 2016: 5). It is also argued that it is more affordable, for example the liquid to treat the symptoms of HIV was sold at 40 cents a glass at a taxi rank (Lecere-Mdlala, 2002: 68). However, Faure (2002: 68) argues against traditional medicine being affordable as traditional healers who claim to cure AIDS charge up to R2500 which is the average of two months wage of an average labourer.

### 2.12. Challenges with integration

In addition to the challenges discussed above, De Roubaix (2016) argues that there is a lack of clarity in terms of how this integration will take place. He suggests that integration can happen if effective communication, mutual respect and trust, reciprocal education and training, two-way referral, and scientific testing of traditional medicine are implemented (De Roubaix, 2016: 160). For example, at present there is a one-way referral system between biomedicine and traditional medicine, and it from traditional healers to biomedical practitioners (Meneses, 2007). There is also minimal identification and testing of traditional medicines, and some traditional healers are getting formal education as per requirement for registration (Faure, 2002). There has also been collaboration in HIV work, as TMPs have received training on how to handle HIV and related symptoms, and training in general safety measures within their practices such as not using the same blade and making use of gloves (Faure, 2002, De Roubaix, 2016). Trust is still however lacking from both sides and biomedical practitioners still need to be educated on traditional medicine as there are many misconceptions.

Some traditional healers in the collaboration front feel side-lined as they want to be treated as equals and not like outsourced help to medical practitioners (De Roubaix, 2016). On the other hand, some medical practitioners accept a degree of parallelism, and others expressed that they

would not collaborate because the methods that traditional healers use are based on superstition and witchcraft (De Roubaix, 2016). They expressed even less trust for those who were prophets as they do not recognise them as performing medical services (Westerlund, 1989). According to De Roubaix (2016), it can be concluded that traditional healers are showing more commitment to the proposed integration of the South African health care system. He argues that biomedical practitioners are sceptical about co-operating with THPs, and are unhappy about the present state of affairs (De Roubaix, 2016: 161). He continues that when compromise is required, it is expected that THPs perform and never their biomedical counterparts.

The above challenges are not limited to South Africa as a study on the integration of biomedicine and traditional medicine in Guatemala found that nine of the participating practitioners (12.7%) had reservations about TM as they trusted their healing methods (Hoyler, Martinez, Mehta, Nisonoff & Boyd, 2016: 9). The biomedical doctors argued that traditional healers misdiagnosed patients to the extent that patients are worse off by the time they get to the clinic or hospital. The biomedical practitioners gave examples of how THPs diagnose parasitic or amoeba infections in cultural terms – e.g. as a curse or due to witchcraft. The biomedical system of diagnosing is seen as the only valid and important one by biomedical practitioners (Meneses, 2007). However, the Guatemalan study found that some biomedical practitioners held positive views on TM. For example, some acknowledged that TM used natural herbs which are healthier and better for people. This is supported by other studies which found that herbal remedies are widely used in industrialized countries, as they are often considered as harmless and organic (Babb *et al.*, 2007: 315).

Some of the traditional medicine healers, on the other have adopted the biomedical diagnosis and treatment perspectives, and they refer patients to medical doctors when they felt it was necessary (Hoyler *et al.*, 2016: 7-8; Meneses, 2007). They also accepted the need for hygiene and acknowledged that germs cause bacterial infections and incorporated this knowledge into their practice. However, medical discourse has also been reported as a reason for integration resistance. For example, King (2012: 1171) found that “understandings of disease within South Africa remain deeply contested and expose underlying tensions about how health decision making is shaped by varied perceptions of illness and treatment options”. In addition, researchers have found that biomedical practitioners in South Africa are resistant to collaboration with traditional practitioners due to the discourse on traditional medicine healers (Leclere-Madlala, 2002: 69). Other studies have found that patients have also been resistant to

the integration of biomedicine and traditional medicine as they do not trust the latter (Babb *et al.*, Cock, 2009; Ingle, 2009). Among the reasons they gave was that primary healthcare was offered for free which made it the better option for the poor. Another reason was that spending money to consult a traditional healer was risky as there are many false healers who may even be registered (Babb *et al.*, 2007). As a participant who had never used traditional medicine said: “Those traditional healers only want to rip you off. They take your money and then the roots do not work. I prefer to come to the clinic where it is free” (Babb *et al.*, 2007: 316).

Van Niekerk (2012) argues that there are four domains of truth whose meaning of proof and fact cannot be generalised among the domains and should rather be understood within them. He places traditional medicine within the mystica domain, while biomedicine is said to occupy the empirica domain, and yet traditional medicine is judged using biomedical standards and ‘medical research ethics’ which supports most of the arguments made against it (Kleinman, 1978; Tangwa, 2007; Van Niekerk, 2012). Researchers have been criticised for this, for example Nyika (2006 cited in Tangwa, 2007: 42) in his study titled *Ethical and Regulatory Issues Surrounding African Traditional Medicine in the context of HIV/AIDS* used criteria that are used in the dominant healthcare system to evaluate traditional medicine without considering its necessity, applicability and terminology. Secondly, the researcher had a bias against traditional medicine which is evident in his use of the following negative words: superstitious, mambo jumbo, bogus, crude mixture, magical and many others.

In addition to the above critique, it is argued that there are culturally-based illnesses, such as the earlier discussed *thwasa*, that the biomedical practitioners do not know and therefore cannot cure (Meneses, 2002, Xaba, 2002, Chavunduka, 1994). The last concern is that in an attempt to regulate the practice by registering traditional medicine practitioners, a space for false healers has opened up (le Roux-Kemp, 2010). This has contributed to the already bad perception and understanding of traditional medicine and practice. Registering TMPs is also exclusive because only a handful of practitioners are allowed. Initially only the *inyanga and izangoma* (TMPs) were registered, but now other healers can register and abathandazeli (faith healers) have never even been considered as eligible to register (le Roux-Kemp, 2010).

The majority of TMPs continue to practice without a licence because they do not know about The Traditional Health Practitioners Act, the Traditional Medicine Association, and the registration process (le Roux-Kemp, 2010: 279). They fear that the government is not too

forthcoming with their true intentions, and they are also reluctant to register because of their fear that TM will be westernised integrated with biomedicine (le Roux-Kemp, 2010: 279).

Supporters of Tm argue that the South African health care system could benefit from having strategies that include both indigenous and biomedicine (Hacking *et al.*, 1988). These supporters further argue that the skill set that traditional healers have make them capable of doing what biomedical practitioners do and even beyond as they deal with the spiritual and social aspects of illness. This, it is argued would not only increase human resources in the health system but it would also bring in something that is missing in the biomedical system. (Muller & Steyn, 1999). This is particularly important to consider as there are illnesses that are associated with cultural beliefs which biomedical practitioners do not know, or which they dismiss as superstition. They can refer such patients to traditional healers who are registered (Meneses, 2007). However, advocates for the biomedical model argue against integration or collaboration because they claim that they are “steeped in a tradition of sound, scientific, evidence-based medicine, believing this to be the only responsible approach to attaining the objectives of medicine, *which is* to diagnose, treat and cure if possible, or at least alleviate and console, with compassion and respect” (De Roubaix, 2017: 159). Therefore, they cannot recognise anything that does not subscribed to the biomedical model of health, and the criticism of the integration of traditional medicine into biomedicine relates to the implication it will have on biomedicine.

#### 2.14. Conclusion

Various definitions of illness exist as well as the medical systems that these are treated in. Many countries, including South Africa, have a pluralistic medical system in which many ways of understanding illness, diagnosing, and treating exist. This is despite the fact that in most countries biomedicine is seen as the true medical system, and the indigenous medicine systems that have been used to treat illnesses for as long as man has been on this planet, are side-lined. Health practitioners in the different systems work differently and are trained differently, and yet integration of the health systems is suggested. This is a challenging task as the ways of understanding the health and illness, and treatment is very different.

#### 2.15. Theoretical framework: Symbolic interactionism

In investigating the perspectives held by students and staff members at Rhodes University, symbolic interactionism and medical pluralism were used as the theoretical frameworks. These

were chosen because illness is an individual experience and it is not uncommon that two people would experience the same thing in the a different way. Secondly, South African has a pluralistic medical system and to look at it without recognising this or looking at it outside of this form of reference would be doing it injustice because illness is framed and influenced by culture and although the ‘western’ medicine has become dominant it is not the only why of understanding, diagnosing and treating illnesses.

Symbolic interactionism rests on the root assumption that the meaning that people have about things determines how an individual would act towards them (Denzin, 1992). Secondly, it states that these meanings are not made in isolation but rather as part of social interactions (Charon, 2001). These meanings are not stagnant but rather go through modification through self-reflection and interactions with others (Charon, 2001; Denzin, 1992). It is about meaning making and social interaction, and that meaning does not end with social interaction (Charon, 2001). Symbolic interactionists understand reality as a manifestation of the continuous social actions that people have with each other as they respond to situations through which they develop lines of action to the various experiences that they go through (Plummer, 1991).

As noted above, interactionists are concerned with the manner in which we make meanings about ourselves, our impulses, feelings and emotions, action, behaviour, and how we explain our actions (Plummer, 1991). It is also about how we define social structures, how we develop understandings of the social order, and how these go through continuous construction as they are constantly being developed through interactions (Plummer, 1991). Finally, regardless of how we may develop a pattern of behaviour and habits, and may have shared meanings, these are however, are open to change (Plummer, 1991). Therefore, although people may share beliefs about some aspects of their illness experience, there are still a possibility of these being shifted and shaped according to their respective experiences. This is because in as much as it emphasises subjectivity, interactionism is not oblivious to the fact that these are not entirely the construction of the individual but rather a result of social construction (Plummer, 1991).

Symbolic interactionism is relevant in this study because it recognises that people do not necessarily see things the same way, in the same light, “interpretations of wellness thus reflect society’s larger cosmological ideas of how the world works and what is healthy and normal” (Flint, 2008: 19). And since there are many cosmological ideas, symbolic interactionism is an ideal perspective because of its belief that reality is based on symbols and it is from these

symbols that facts are constructed (Charon, 2001). Because ideas and views change, and people do not hold a static view of their health or illness, it is ideal to have a theoretical framework that recognises that there are various ‘truths’ about health and illness.

#### 2.16. The medical pluralism paradigm

The concept of pluralism can be defined as a theory that denies the existence of just one ultimate principle, as it recognises the reality of various principles, and that “the force of any brand of pluralism depends on its ability to characterize and problematize some prevailing monistic orthodoxy” (Cant & Sharma, 1999: 3). Medical pluralism acknowledges that medical ideologies are informed by the beliefs that are held by society, especially by health care practitioners and policy makers, which are culturally informed, and medicine is said to have a cultural as well as a biological dimension (Westerlund, 1989: 173). There has always been the possibility of choice between different kinds of practitioner, between consulting or self-prescribing, and there have always been multiple ways of understanding health and sickness (Cant & Sharma, 1999:1)

It is important to acknowledge that patients and practitioners have various ideological basis on which their ideas on health and healing are informed by (Johannessen, 2006). This is despite the incompatible explanations that various medical systems may have about whatever the patient is suffering from (Mbelekane, *et al.*, 2017). The different ways of explaining, seeing, and treating illness is through the recognition of the co-existing systems of medicine that are found in a given society (Mbelekane *et al.*, 2017). However, medical pluralism does not mean equal recognition of all health systems, as critics argue that the biomedical system has “secured a position of social, economic and ideological hegemony in the health care market as a result of its own professional project and through the support of the state” (Cant & Sharma, 1999: 1). Traditional medicine is marginalised as it is seen as unscientific and superstitious (Westerlund, 1989).

Due to the plurality of knowledge on health and illness, it would be problematic to integrate the varied health systems (Green, 2012; Johannessen, 2006). However, in many countries, people from all socio-economic and educational strata utilise both biomedicine and traditional medicine, and this creates a medical pluralism that integrates both models and has implications

for the treatment or management of disorders and compliance with therapy, rehabilitation, and medical regimens (Johannessen, 2006).

## Chapter 2: Data Analysis

### 3.1. Results

The aim of the study was to explore what motivates participants to use either biomedicine or traditional medicine or both. As noted in the chapter 3, participants included students and staff at Rhodes University. The initial target group was the student population, but black African members of staff had to be included as it became apparent that most students taking part in the study did not make their own choice in using traditional medicine. They said that their parents or other family members imposed traditional medicine on them. Staff members were therefore included for this purpose, to find the motivation for use beyond primary socialization. The following table summarises the participants' reasons for using traditional medicine and biomedicine:

Reason for use	Traditional medicine	Biomedicine
The type of illness the person is experiencing	<ul style="list-style-type: none"> <li>• Matter not being addressed by biomedical practitioners;</li> <li>• Experiencing a spiritual matter;</li> <li>• Experiencing a social illness;</li> <li>• Ancestral punishment.</li> </ul>	<ul style="list-style-type: none"> <li>• Things that affect the body and all its organs - e.g. serious injuries, tumours etc.;</li> <li>• Minor and acute illnesses.</li> </ul>
Availability	<ul style="list-style-type: none"> <li>• Hard to find good traditional healers;</li> <li>• Lack of botanical knowledge to find medicinal herbs;</li> <li>• Not always readily available.</li> </ul>	<ul style="list-style-type: none"> <li>• Readily available;</li> <li>• Over the counter medications;</li> <li>• Buying power through medical insurance;</li> </ul>

		<ul style="list-style-type: none"> <li>No knowledge needed as it is a trusted profession.</li> </ul>
Influence	<ul style="list-style-type: none"> <li>Family, cultural and religious beliefs.</li> </ul>	<ul style="list-style-type: none"> <li>Family, media, state, university, medical establishment etc.</li> </ul>
Geographical location	<ul style="list-style-type: none"> <li>Mostly rural areas.</li> </ul>	<ul style="list-style-type: none"> <li>Mostly urban areas.</li> </ul>

Upon learning the impact that the parents had on the decision that students make with regards to health systems, it seemed useful to get the insight of staff members who are parents and grandparents, and who use or had used TM at some point in their lives. A questionnaire was completed by these members of staff, and the majority agreed or strongly agreed to the question whether exposing young adults to TM increased the chances of the young adult using TM. This response supported what the students had said in the interviews, that their parents or family members influence them on the use of TM. Students also said that secondary socialization also played a role in the decision-making process on TM. What people are taught in school and sometimes by peers, and the media influences how they perceive, understand and act on health issues. For example, two pharmacy student participants noted how they have been taught that there are hundreds of diseases that science cannot identify, and this may influence consultation with TMPs.

In this study, the dominance of biomedicine is evident in the participants' way of thinking about illness, treatment and diagnosis which is reflected in their biomedical centred health experiences.

### 3.2. Discussion

The aim of the study was to find what views regarding the use of traditional medicine and biomedicine are held within the Rhodes University black community. The themes that were identified and under which the data was organised and analysed are: illness, traditional medicine, biomedicine, accessibility, affordability, family influences, social influences, knowledge, reliability, and integration. These themes will be expanded on using collected data,

reviewed literature, and symbolic interaction. The discussion will look at how each of these themes shapes the participants' use and understanding of traditional medicine and biomedicine. Central to the decision is the belief system that each individual holds when it comes to illness as this is the foundation of their explanation of symptoms, diagnosis and treatment options. As all societies and individuals have what called is the 'disease-theory system' to identify, classify and explain illness (Foster & Anderson, 1978 cited in Akpomuvie, 2014:52). The first part of this discussion examines the meanings people place on the concept of illness as this shapes a society's and individual's formation and interpretation of the cause of their illness. This will include the reality that medical pluralism is common in many societies, specifically in South Africa, as various medical systems - influenced by the diversity in people - exist in parallel to one another (Sindiga, 1995; Westerlund, 1989). For example, most Africans use biomedicine in the day, while at night they use traditional medicine with the hope of maximising their chances of restoring their health (Sindiga, 1995).

### 3.2.1. Lay definitions of illness

When participants were asked what they regard as ill-health, most of them said that it would have to be something that hinders the ability to do daily activities. It is when what they saw as 'normal' was disrupted which may result in weakness or sometimes even death. They also said that it is something that can either manifest physically, emotionally, psychologically, or spiritually. However, some participants considered things such as addiction and deviant behaviour as illnesses. Others said that when one's life is not progressing and full of challenges then they are ill. For example, one participant said that he used TM when he was feeling tired to help him focus and energised throughout the day. However, what he referred to as TM were capsules with an organic label said not to be tainted with chemicals. This supports Cocks and Dold (2000,1506) finding that TMPs are modernising by selling refined herbal and animal remedies in *amayeza* (TM store) that are in modern packaging. Another participant considered her son's mischief and alcoholism as an illness for which she had to seek treatment.

One participant came with an entirely different perception of illness from the above definitions. He defined illness in objective terms similar to the medical definition of illness, which traces it to bacteria or virus origins. However, given that he said that his family is committed to only using biomedicine, it is understandable that he has adopted a biomedical definition of illness. An alternative explanation is that he read on the biomedical definition of illness prior to the interview.

It is evident from the above discussion that there are varying understandings and definitions of illness. These various definitions are used as themes in the following sections.

### 3.2.2. Illness is not being yourself

Mbi, one of the participants said that when you are ill it alters who you are, and you never really regain who you were before you got ill. This is with particular reference to chronic illness, mainly because of the limitations that treatment has:

I was diagnosed with lupus which is a chronic disease. Much as I went to the doctors and everything, it was a matter of I have to depend on medicine and everything and that's not a life you want to live. So I'm going to say biomedicine is reliable only to a certain extent because obviously when you go to the doctors you have this thing that I just want you guys to make me better. Make me the person that I was before. I don't want to rely on medication for the rest of my life. ... and there also comes a point where you find that there might be complications and then the doctors can't do anything.

(Mbi, Grahamstown, 2018)

Another participant, Nge shared that before he was diagnosed with cancer and treated, he used to ignore illness but now he acts immediately. He also spoke of how he is on constant painkillers because in as much as the cancer is no longer there, he still experiences pain:

I underwent physical pain, suffered from muscle spasms and a pinched nerve that used to give off muscle spasms on my entire left leg. So I had to get medication, I mean strong painkillers for that. It's gotten better with time, but I mean there is still that residual damage, so I suffer from pain from time to time.

(Nge, Grahamstown, 2018)

The transformation brought about by illness in a person was evident in *thwasa* (initiate for traditional healing) who decided to accept her/his calling and get treated for illness that is induced by a calling or delaying a calling to be a healer (Chavunduka, 1994; Mutwa, 1996). It is similar in that it is said that one emerges from the training renewed with skills and a new social status, making them different from who they were before *ukuthwasa*.

For one student participant who also happened to be a traditional healer, the illness changed her in that before when she got ill she sought help from doctors and saw illness as something that had to be rectified in her. After she was trained as *igqirha* (traditional healer), illness for her was interpreted as the ancestors' way of communicating that there is someone who needs her help, and that whenever she is not feeling well, she has to find the person who needs her help and in turn she becomes healed:

The weird thing actually is that I had been sick before, well my body had been. That's before I started the process of *ubugqirha* [training as a traditional healer]. I spent

thousands just to try and treat myself, I'd go to the next doctor and he'd say you have this until I went through the process of *ubugqirha*.

(GFA, Grahamstown, 2018)

And unlike before her initiation she now claims that:

When I'm not feeling well the first thing that comes to mind is either there is someone who is sick or need my assistance that I need to *uyeza yena* [who I need to treat]. For me to treat myself is I need to get in touch with the person who needs my treatment.

(GFA, Grahamstown, 2018)

### 3.2.3. Illness is not being normal

Illness was considered to be anything that interrupted the person who is considered to be ill or those around them as being outside of what is considered normal. An example given by some participants is when children are acting out of character, which includes misbehaving and drinking. It was seen as something that prevents the affected person from participating in what would normally be their daily activities or things that they would normally choose to do. Being in hospital was also considered as abnormal as it brings about a sense of fear and something you can't handle. For example, one participant said that if he was not in hospital and could still run on the field, then he could sweat out the flu, and that he was not ill. Another participant agreed with this understanding of illness by saying that 'unless something started freaking her out she did not pray nor seek professional help.'

### 3.2.4. Illness as an unpleasant feeling

A common theme between literature and the responses from the participants is that illness is categorised as mild and serious. For example, one participant even went as far as stating that 'serious illness is being ill in the full sense of the word, while mild illness was just being sick. Being sick or having a mild illness (*umkuhlane*) was considered as more of an unpleasant feeling which throws them off rather than hinders their normal day today activities. The individual does not need to consult a health professional. As another participant said that mild illness could be fought off by simply being active. This participant was battling flu when the interview was conducted, but he said that he was not ill and that he would be back to his normal self after he played soccer.

### 5.2.5. Illness is not being in control

Participants spoke about illness, especially chronic illness, as losing control of their lives. This is similar to Charmaz's (1983: 165) explanation that "...chronically ill persons frequently

experience a crumbling away of their former self-images without simultaneous development of equally valued new ones. The experiences and meanings upon which these ill persons had built former positive self-images are no longer available to them.” This was a common theme in the participants’ definition of illness as most of them said that when one is ill they experience a great sense of loss of self in that they are unable to control what is happening in their body, and cannot do anything about it regardless of how hard they try. This sense of a loss of control was expressed many times when participants spoke about chronic illness such as cancer, and an individual is forced to seek help from traditional healers or medical practitioners.

### 3.2.6. Responding to illness

As discussed earlier, what an individual believes about illness influences how she/he responds and who to consult for treatment. People come to this understanding of the cause of illness through interaction with multiple individuals and social factors. As Ross (2008: 16) notes that “...whether people use traditional and/or western medicine, their worldviews regarding the aetiology of illnesses and disorders, and the persons who are likely to be consulted to restore health and well-being, are often influenced by differences in socio-cultural experiences, ethnic histories, and family backgrounds.” For an example if one is exhibiting what is seemingly abnormal behaviour and your understanding of illness is framed in a biomedical sense, you will have the person treated for mental illness, while another person who interprets it a denial of ancestral calling will be recommend for *thwasa* initiation (Rankopo, 1996). As illness disturbs the person, a loss of self is experienced and the holistic nature in traditional healing takes this into account. When an individual is ill due to a calling, the healing and initiation includes how to regain a sense of control of their circumstances through spirits (van Dijk, 2000). The *thwasa* initiation ceremony provides physical, psychological and spiritual healing as the initiate is given the chance to understand what they are experiencing in a wider cosmological and social sense (Deacon et al, 2004; Mutwa, 1996).

### 3.2.7. Accessibility

When asked about the role that accessibility plays in choosing a traditional healer, four staff participants said that proximity to a traditional healer did not impact whether or not they would go to the person. They said that the best traditional healers are those whom you travel long distances for. Other studies had similar findings, for example, a man who was disappointed by traditional healers in his area had to travel a long distance to find a healer who eventually helped with his suffering (Xaba, 2002: 27; Xaba, 2007: 337). This was also common with the

student participants who reported that if their parents asked them to consult a traditional healer, they would go home. First, they believe that the problem will persist until they consult the relevant person, and secondly, because they do not know who they would have to consult and therefore have no option but to go home.

The lack of proximity to a traditional healer can lead an individual to use biomedicine if it is accessible, especially if the individual in question does not have knowledge to identify herbal plants and how to use them. Some of the staff participants who said they had herbal knowledge had gained most of it while they were still living on farms, while others, including students argued that they had been exposed to it by elderly people in their families. A significant amount of students did however argue that they would not be able to navigate herbal medicine on their own.

Participants also said that the individual's location affects the choice of health practitioner that they consult when they are not feeling well. For example, one student said that when she is at home, which is in a rural area, she is more likely to use traditional medicine because the domestic worker in her home is a *sangoma* (healer), and she is surrounded by elderly people who know traditional medicine. She also said that the natural resources needed to prepare what would be needed for whatever she is experiencing, is much easier to find than than is access medical professionals and facilities. This means that her choice of traditional medicine is due more to proximity than preference.

Most participants said that biomedicine is chosen because medical professionals can issue medical certificates if they need to be excused from either school or work. They said that time off work or school could be used to consult traditional healers. It was interesting to learn that Rhodes University accept sick notes from traditional healers, and this was stated by a male participant. This was one of the reasons why this participant solely relies on traditional medicine, and the other reason is that traditional medicine is free most of the time as he has botanical knowledge and he works with plants on a daily basis.

#### 3.2.8. Financial constraints

Contrary to the above, one female participant argued that free public healthcare is why she will not go to a traditional healer. Nevertheless, a significant number of the participants reported

that they found traditional medicine to be cheaper than biomedicine. They argued that there is no set rate that you are charged by traditional healers, and it could be as little as R50 for consultation and treatment. Participants further stated that some traditional healers do not charge anything until the services rendered yield the promised results.

However, because life has become so medicalised, what is labelled convenient within the biomedical health systems is also problematic in that it is run as a business (Illich, 1976). This means that there is a profit motive in the biomedical health system, and businesses such as medical insurance cause biomedicine to be very expensive. In addition, should one choose to go to a private doctor instead of using the public sector, they are likely to pay a consultation fee and get a prescription which they have to pay for at private pharmacy. However, one participant argued that the process is quite the same in traditional medicine as some traditional healers demand payment as soon as clients arrive, and after healers have consulted spirits or ancestors they usually ask for additional payment for the treatment. The participant noted that the only difference is that you get everything in the same place, although some traditional healers do not always prepare the medication themselves.

Another difference between traditional medicine and biomedicine payment for services is that healers are sometimes paid in kind as payment is often not exclusively monetary (Meissner, 2009: 143). A few participants said that in traditional medicine, usually a small fee is paid initially, and the rest when treatment is complete or when the patient is healed. Other researchers have found that preference and continued use of traditional medicine is due to an economic contract between the two parties where the healer receives the bulk of the due payment only when the patient is cured, and this makes it mutually beneficial (Leonard, 2001 in van Rensburg, 2012: 635).

As noted earlier, there was disagreement among participants when it came to the affordability of traditional medicine. While some found it relatively affordable compared to biomedicine because you can pay as little as a total of two hundred for everything. On the other hand, most medical doctors would not even see you for this amount, and you still have to pay for medication from a pharmacy. Other participants argued that traditional medicine can be as expensive depending on how serious your illness is, and this is a similar finding in other studies (Karim *et al.* 1994: 5 in Meissner, 2009: 193).

Research indicates that the high cost of traditional medicine is mainly due to transport costs and population growth (Van Rensburg, 2012). With the former it is argued that people tend to consult traditional healers who do not live in their area, and sometimes are paid to travel to patients. Population growth, on the other hand, has created a great demand for herbs and other resources needed in traditional medicine, and this makes it more expensive. As Van Rensburg (2012) argue that it is in fact some diviners who are expensive as they can charge double what is charged by medical practitioners. However, other researchers argue that many traditional healers, particularly in the rural areas, do not charge much and some do not charge any fee at all as they regard the practice of medicine as a service to the community and not a source of wealth (Chavunduka, 1994: 57; Meissner, 2009: 143). Such healers are rewarded a high social status due to their ability to heal, and their ability to access the world of spirits. However, some healers may expect the patients to give them gifts from time to time, and this method of payment may, in certain instances, become very expensive in the long run (Chavunduka 1994: 57). This shows that payment in traditional medicine is not a stable or reliable matter as it can vary from place to place, and on whether it is a rural or urban area.

### 3.2.9. Social influences

Participants said that family, friends, the media and education influence their decisions on what kind of treatment they seek. As earlier mentioned, parents play a key role in influencing their children in using or not using a particular health system. For example, one participant said that his first reaction when he was not feeling well was to tell his mother:

Mama, nd'yagula' [mother, I am sick] [laughs] Ndifonela umamam ndithi ndiyagula.  
[I call my mother and say I am sick]

(Athi, Grahamstown, 2018)

Other research findings confirm that the home is a space where health decisions are mostly made, and the initial health-seeking behaviour starts (Mbelekane *et al.*, 2017: 210; Williams, 2002: 149). The household then becomes a curative space of care where meanings of illness and medications are shaped and where decisions on treatment are negotiated (Kamutingondo *et al.*, 2011). However, this is not to say that parents or relatives are always successful in influencing their children. For example, a staff male participant said that he uses both biomedicine and traditional medicine, but his children refuse to use traditional medicine as they find it unpleasant:

Bathi 'hai ikrakra lento mna andikwazi uyisela lento ikrakra' [they say no, this thing is bitter, I cannot drink it].

(Sir Gobz, Grahamstown, 2018)

A student participant said that when a doctor diagnosed him with a serious illness, he consulted his mother and the rest of the family on what treatment he should take. The family advised that he seek help from a traditional healer, but he and his mother objected and he opted for the medical doctor's treatment. Research shows that it is not only parents who influence children, but that adult children influence their parents too (Rankopo, 2006). Most student participants said that they reluctantly obeyed their parents' suggestion to use traditional medicine. As one of them strongly stated that she does not like using traditional medicine, only when her parents ask her to use it:

I don't use it for everything like I use it for certain things and when my parents tell me you must use this. It's my parents that initiate me using it.

(Mphilo, Grahamstown, 2018)

The way in which language is used also affects the way in which people perceive traditional medicine. Many of the participants who do not use traditional medicine or who were forced by their families to use it, saw it as an unreliable, untested and un-transparent system. They said that traditional medicine employs dubious practices, for example, there are no labels to show the ingredients in the concoctions, and consulting spirits and ancestors for a diagnosis is strange. Such language about traditional medicine coupled with accusations of witchcraft and depictions of gruesome images and stories of the use of human body parts in their medicine has also not helped their image and reputation (Khoza & Maphoma, 1994). This is the reason why some participants rely solely on biomedicine or refraining from using any medicine but trusting in prayer and water.

For many participants, however, relying on prayer and water are in the initial response to the problem. For some the next step, if the first had not worked would be analysing their own symptoms, for some even finding the source of the illness and then going to the nearest store that sells medicine so that they can self-medicate. Cocks and Dold (2000: 1505) stated that this is an important stage and many illnesses are often managed at this stage. For example, one participant when asked about his initial response to illness, said that he does not get sick a lot but when he does, he stated:

It would depend on the feeling but medicine would probably not be the first thing that comes to mind because I don't like medicine. I just let my metabolism heal me, but I always want to get to the root and then from there I can decide what to do. I normally wait. I normally give myself about a week to just let my body adjust before I intervene but if I see that it is getting hectic, with the basic knowledge of medicine that I have,

basically from home, then I know If it's persistent pain then I can take a panado if it's a headache I can also get disprin, grandpa, panado, and those few basic medical knowledge. But then I think I've not experienced an extreme situation, just those light things something that I can manage by myself.

(Anele, Grahamstown, 2018)

So a significant amount of the reasoning about the choice to use or not to use a specific medical system relied heavily on what participants knew about it. This was evident with most participants who admitted that they are influenced more by the positive adverts on biomedicine, and that they do not know much about traditional medicine because it is not publicly advertised. They also said that ingredients of biomedicine drugs are explained on the containers and the level of training required from the professionals is also common knowledge. This is why most participants support collaboration between the two health systems as this would increase the scope of medical systems, and it would also make traditional medicine better known, possibly better tested and transparent to its users or potential users. However, some participants opposed collaboration as they believe that traditional medicine poses a risk to biomedicine as it is not trustworthy. They also believed that transparency would not be achieved as traditional healers would not be willing to reveal the truth about what is in their mixtures and potions.

The understanding of what illness is also determines whether one will make use of the pluralistic medical system. For example, one participant said that she will use whatever health system to get well and preserve life. As Mbelekani, Young-Hauser and Coetzee (2017: 224) also note that “If an illness persists, some individuals who use traditional medication might switch to biomedical treatment, and those who use biomedical treatment might revert to traditional healing practices or remedies.”

#### 3.2.10. Reasons for use

Participants who use the pluralistic medical system said that they buy over the counter medication for mild sickness, but if the problem persists they consult either a medical doctor or a traditional healer, or both. For example, a female participant who has a chronic disease uses medicine prescribed by a doctor, but she also uses traditional medicine to ease the symptoms and strengthen her immune system. Participants who are knowledgeable about herbs use mainly traditional medicine instead of self-medicating with over the counter medicine from the pharmacy.

There are diseases that medical doctors cannot diagnose, but traditional healers can deal with. For example, a study found that a man had a mental illness after breaking his vow to keep silent about his girlfriend being a practicing witch (Rankopo, 1996: 22). His mental illness was explained as a punishment by traditional healers, but medical practitioners said that he was suffering from psychological distress. Hearing voices is also diagnosed as mental illness in biomedicine while in traditional medicine it may be interpreted as being bewitched or a calling by ancestors to become a traditional healer (Mutwa, 1996). A participant who was newly initiated as a traditional healer spoke about her experience of many failed consultations with medical doctors:

That's before I started the process of ubugqirha [becoming a traditional healer]. I spent thousands just to try and treat myself. I went from doctor to doctor and they would say you have this or that. I stopped being sick when I went through the process of ubugqirha. (GFA, Grahamstown, 2018).

This is a common belief among Africans, for example, a study in Ghana found that students and hospital workers maintain a belief in the spiritual causation of certain illnesses, and how they are best treated by traditional priests/priestesses or in Christian spiritual churches (Meissner, 2009: 35).

The third reason that was given for using traditional medicine was to protect oneself from evil spirits. Most participants said that they burn *imphepho* (incense) to protect themselves from evil spirits, and they also use *isilawu/ubulawu* (dream root) which is for dream interpretation. These are just two of the many things that participants said they use as a protection from evil spirits. Some said they did this on a daily basis, some before special occasion and others when they had been experiencing something. As one participant said:

Pretty much everyone does it, *wonke umntu uyaqiniswa* [everyone is made strong] right? I think let's say once in a while I do consult to protect myself against evil spirits. That's *uqiniswa* [being strengthened].

(Athi, Grahamstown, 2018)

Other researchers have found that in African societies the process of protection and strengthening is a continuous one, which starts even before a child is born as the mother and those close to her are expected to refrain from things that are taboo, and do this to protect the child from evil spirits (Mndende, 2009; Rankopo, 1996: 14). For example, expecting parents should not have extra-marital sex as this could result in the child having what is known as *mopakwana* [a disease that a child gets - Botswana] (Rankopo, 1996: 15).

The fourth reason that was given for using traditional medicine by participants is that it is not as toxic as biomedicine. They believe that traditional medicine contain cleansing elements or something that strengthens the body's defences. The individual is not only treated but also is prevented from further sickness. Biomedicine on the other hand was seen as toxic because it has side effects and has the capacity of causing further damage or illness. However, one participant felt differently, she has high blood pressure and she has been admitted to hospital because of the medication she was given by biomedical practitioners. She believes that traditional medicine can cause liver damage and she told a story about how the advancements of BM were instrumental when she started experiencing abdominal pain:

I had a pain *esibelekweni* [intense pain in the uterus]. I went to the San [clinic at Rhodes University] for painkillers for my periods, and then I went to the hospital because the pain couldn't stop. The hospital said I was pregnant, but the pain did not stop. So I went to Port Elizabeth for a screen and they said that I had fibroids. I decide what to do, but a traditional healer would have just said 'drink this' without looking inside, which could make me worse because they cannot see inside, they just assume.

(Linda, Grahamstown, 2018).

### 3.2.11. Reliability

In the above comment, traditional medicine is depicted as an unreliable and risky method, which does not have the necessary technology to ensure a full investigation into the presented symptoms. Linda is like many people who do not trust the methods and medicine used by traditional healers. For example, research on plants and roots used by prenatal women and during childbirth found that one of the plants *agapanthus africanus* was poisonous when large quantities were used (Kaido, 1997). However, biomedicine is said to cause *social iatrogenesis* which Illich (1976) argued robbed people of the ability to cope with pain. Furthermore, he argued *clinical iatrogenesis*, which refers to the fact that many technological and pharmaceutical 'advances' have serious side effects that may be worse than the original illness (Illich, 1976 in Senior & Viveash, 1998: 14-15). What this proves is that there is no system that is without problems and gaps (Meissner, 2009: 7). As a participant argued:

The reason I don't use biomedicine often is because I don't trust it because they tell you it might cause a headache. So you are healing one problem and creating six more problems. So that's why for me it's better to let my body heal itself because I don't think there are side effects when my body heals itself.

(Ngam, Grahamstown, 2018).

When the participants were asked how reliable they found the two health systems, most of them had problems with both systems. For example, one participant when asked about potential collaboration between biomedicine and traditional medicine, responded as follows:

You know what, I don't think that will happen because the people who make the traditional medicine will never reveal to us what they put in it. Because sometimes they put things that they don't want people to know is inside. Things that are put in are sometimes very dodgy as we see in movies. ... I mean in movies sometimes they put someone's finger, you see now there is a body part. Now who would want to drink that? That must have come from somewhere. If that's the case, if what we are shown in movies is really how they make medicine who would want to buy that?

(Fufu, Grahamstown, 2018).

The South African Medicines and Medical Devices Regulatory Authority Bill passed Act 132 in 1998 to ensure the registration and regulation of the medicine used by traditional healers to ensure safety (WHO, 2001). However, it is not enforced as Fufu and others argue that traditional practice remains essentially unregulated, and in certain circumstances, harmful or even fatal (Meissner, 2009: 5). As noted above, biomedicine is also harmful as Makary and Denial (2015) note that medical error was the third leading cause of death in the United States. This makes arguing against traditional medicine on the virtue of potential fatality risk questionable.

There are traditional healers who argue that it would be to their advantage if traditional medicine is regulated and traditional healers to get formal education in traditional medicine which is scientifically recognised as this would give them the accountability, reliability and testability that they are said to lack (Flint, 2008: 193). As a participant in Flint's (2008) said:

Now that the government has changed, they are giving people [healers] the opportunity to change themselves and improve themselves. Now for instance I just buy a grinding machine instead of wasting material like I do when chopping like this... those who are becoming sangomas should go to school to learn mathematics to learn how to mix what with what. Our laboratories are our ancestors, they say "no /you've made too much muthi, just take some of that out, put more of this stuff and this stuff." But now we cannot rely on our ancestors to prove ourselves, we must have laboratories. We must have people who can purify and test our medicines to see if it is good for selling to other countries. We must have our own laboratories and purifiers to keep pharmaceuticals from taking advantage of us.

(Muzi Mthenjwa in Flint, 2008: 93).

As discussed earlier, this is one of the reasons why traditional medicine is not trusted. It is not tested and the practitioners rely on dreams and orally passed knowledge from generation to generation (WHO, 1996 cited in Gyasi, 2011: 41). However, there are herbal plants that give

traditional medicine validity, for example aloe vera, hoodia, pelargonium and agapanthus africanus, pentanisia prunelloides and gunnera perpensa (ACB, 2011; Kaido *et al.*, 1996; Wynberg & Chennells, 2008). There is also strong scientific evidence supporting alternative healing methods, including traditional medicine (WHO, 2002).

### 3.3. Religious beliefs

Most participants said that they go to church, but this did not affect whether or not they use traditional medicine. However, one participant said that she has stopped using traditional medicine because she is 'saved'. As a Christian, she does not want to be involved with spiritual rituals and traditional healers who seek guidance from deceased ancestors. When she is ill, she prays to God for healing. Her understanding of traditional medicine is that one need to believe in ancestors as superior beings who can help cure illnesses, and since she did not believe in them it would not work:

I don't believe in traditional things. The ceremonies and everything, the ancestors. I don't praise them. You need to believe that it's gonna work, so for it to work you need to believe that they are ancestors and that they work.

(Busi, Grahamstown, 2018)

Some participants who are Christians and use traditional medicine also do not like the spiritual aspect in traditional medicine. They also do not believe in ancestral spirits, but unlike Busi, they use herbs for various ailments. An interesting finding is that these participants did not consider themselves as using traditional medicine because they did not consult traditional medicine practitioners who evoke ancestors in their practice. In this sense having faith in whatever it is that you are using is very important as it is claimed that without the individual believing in it, it will not work or if it does, the relief will not be long lived. As Buhrmann (1986: 25) argues "if a client is not convinced that modern practitioners can intervene successfully in any given situation, he will psychologically and physically resist modern treatment."

### 3.4. Level of education

Although the stereotype that traditional medicine is an outdated, primitive practice, data collected from Rhodes University students and staff members, and reviewed literature show that it is still a relevant health system and that it is also used by educated people. A study found that educated people living in urban areas continue to consult traditional practitioners (de Jong,

1991 in Meissner, 2009). This study concluded that demand for these services may even increase with modernisation since healers are skilled in helping people to cope with the psychological and social stresses that often accompany rapid social and economic change. All but two female participants who said that they use traditional medicine are educated, which shows that the use of traditional medicine has very little to do with one's level of education. As Flint (2008) writes about two medical doctors, one insulted traditional medicine at a conference, and another started her own clinic where she practiced both traditional medicine and biomedicine giving the patient the opportunity to make their own informed choice about the options of treatment available to them.

### 3.5. Jack of all trades

Although the focus was mainly on the relief from illness and social disruptions, it became evident that traditional practitioners played a bigger role than just divining and healing. As noted earlier, traditional healers “are skilled in helping people to cope with the psychological and social stresses that often accompany rapid social and economic change” (Meissner, 2009: 35). For traditional practitioners the healing of illness is “simultaneously political, therapeutic, judicial, and religious; they cover an extensive field of competencies and functions that place the efficiency of the treatment within a more enveloping efficiency...” (Meneses, 2007: 355). As one participant said that he and his team mates have used traditional medicine to win a game of soccer. Their coach and manager put *muthi* (tradition medicine) on their soccer uniform to counteract the opposing team's evil *muthi* whose sole purpose was to limit their ability to win the game. He, however, admitted that his team won games that they would not have won if they had not used *muthi* or performed rituals that they were instructed to use or do. He said that they won games that they would have never won on their own.

Another participant said that he used herbal medicine to assist him in his studies, while another said he would use traditional medicine to attract a girl he was interested in. As another study found that people use traditional medicine due to social pressures such as unemployment, pursuit of success, levels of crime and other social issues as reported by (Xaba, 2002). Participants said that traditional healers are also involved as mediums between the living and the dead ancestors during family rituals. For example, one participant said that in his family when the slaughtered animal does not cry a traditional healer would be consulted.

### 3.6. Collaboration

One of the items on the questionnaire distributed to staff members was on collaboration between biomedicine and traditional medicine. Five participants responded that integrating traditional medicine into mainstream medicine would increase its use, but three participants felt that it would not. A similar pattern was evident with the participants that were interviewed who said that the collaboration would be a good thing because it would provide the healthcare system with more resources. This means that more people will get the medical attention that they need. Other reasons in support of collaboration were that this would give traditional medicine the chance to be tested and for it to prove its validity, and those that had previously not been exposed to traditional medicine would have this option of treatment. One participant also spoke about the good that holistic traditional medicine would bring to biomedicine practice. She argued that one should be pluralistic in his/her health practices so that both the physical and spiritual wellbeing is treated, and she also said that the bulk of what traditional healers do is spiritual and emotional therapy. Another participant argued that the collaboration would eliminate the idea that traditional medicine is only for black Africans because it would make it accessible to everyone who seeks medical care.

However some participants believe that collaboration between biomedicine and traditional medicine is a bad idea. One participant argued that this would taint the prestige that is enjoyed by medical professionals who she believes have earned the social status because their methods work. This suggests that she believes that traditional medicine does not work. She further argued that if traditional medicine is dispensed in clinics and hospitals, and it fails the clinic or hospital would be discredited. She went as far as making an illustration of how it would not be different from a child being taught by an old ‘uneducated’ grandmother who knows nothing about teaching, when there are trained teachers who you can trust to teach the child.

Participants also claimed that tradition medicine is problematic because it is not as effective as biomedicine, and that it merely tells you the directions that are not clear when you will get home. This emphasises the earlier discussed notion that traditional medicine is not to be trusted because traditional healers lack scientific training in medicine, and that people fear what healers include in the concoctions. One participant also stated that traditional medicine is the reason why some people on chronic medication do not adhere to their biomedical treatment. She believes that if the two health systems where to collaborate, patients would be more open

to discussing taking traditional medicine in their consultations with medical professionals, and this could make the treatment more effective.

## Conclusion

The study found that the participants from Rhodes University in Grahamstown, like in other parts of South Africa, use both traditional medicine and biomedicine when they are sick, where the individual either makes use of one or the other or use both when faced with different ailments. This use of a pluralist medical system is influenced by the participants' cultural background, society and medical discourse, and the biomedical knowledge. The study found that the basis of the choice that participants make about their health depend on how they understand sickness. They either see sickness as a bodily condition or as a holistic issue where more than a dysfunction in the body could be the cause of the illness. Both traditional medicine and biomedicine have different understandings of illness which impact or influence how they respond to illness. In traditional medicine, spiritual health is an important aspect as traditional healers, particularly diviners, use it to diagnose and treat patients. It is also believed that spirits, especially ancestral spirits and witches, can also cause sickness. This is when an ancestor either neglects the person thus making them vulnerable to evil spirits or when an ancestor needs to get the person's attention to accept the call to become a diviner and any other matter that they need resolved. Participants understand that in biomedicine the focus is on the body, which is viewed and treated like a machine. When a part has a problem, medical tests are carried out to find the cause of the problem and it is treated using medical drugs or performing surgery. The patients play a minimal role in their healing as their duty is seen as just adhering to the practitioner's instruction on treatment.

Although the reviewed literature on health care seeking behaviour suggests that people consult both traditional healers and biomedical practitioners for acute sickness, some of the participants in this study do not agree. They view acute sickness as something that they can treat themselves through unconventional treatments such as taking soda water or drinking urine, using herbs, using medications that they get themselves or just simply drinking water or exercising.

Reviewed literature on traditional medicine in the Eastern Cape and other parts of South Africa show that there are differences in TM practices due to different traditions. The main influence is the culture of the region, especially the language which is used to give meaning of health-related matters. However, it is also impossible to deny that there is a lot more that is similar than that which is different because of the shared cosmology on health and illness. It is for this reason of shared cosmology that various practices, such as *ukuthwasa* (the period of initiation

that one undergoes in order to become a sangoma/healer) common across regions and an initiate (*thwasa*) may be called or may choose to be trained under an initiation school that is outside of their own region, even outside of their country.

Although biomedicine is the dominant health system in South Africa, and traditional medicine is marginalised, most indigenous people use traditional medicine. This is why the WHO (2002) suggests integrating traditional medicine into the mainstream medical system as this would increase resources and help governments reach their goal of providing universal healthcare. However, this suggestion has been met with resistance by practitioners and patients in both the biomedical and traditional health systems. South Africa has not integrated the two health systems, but some traditional healers refer patients to medical practitioners and very few medical practitioners refer patients to traditional healers. As one doctor in another study said that he could ask the patient's family to take him/her for traditional healing, but that he could never refer a patient to a traditional healer. Much still needs to be done to change the way that traditional medicine is viewed, and an important part of that change will be in realising that these are two systems, with different cultural influences, cannot be understood in the same light. It is these meanings or understandings of the two health systems that participants are informed by when they make a decision about their health and treatment when they are sick. Who they decide to consult and what they decide to do when they are sick is based on whether it is something that they can handle or if it is something that needs help from traditional or medical practitioners.

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## Appendix

### Appendix 1: Consent form



### Academic Research Information and Consent Form

#### Department of Sociology Rhodes University

**Research project name: A sociological analysis of the Rhodes University Students' and staff perceptions on the use of traditional medicine and biomedicine**

#### Participant Information Sheet

We would like to invite you to take part in the above-named study but before you decide, please read the following information.

**What is the purpose of this study?** the purpose of this study is to understand what informs a patient's choice and their use of medicine

**Who is doing the study?** The study is being conducted by Buncwanekazi Mankantshu

**Who is being asked to participate?** Participants need to be either an employee or a student at Rhodes University, they need to be South African and IsiXhosa or Zulu speakers.

#### Your rights as a research participant

Participation in this study is completely voluntary and anonymous. Information gathered during the research will be used solely for the purpose of this study and all efforts will be made to ensure the confidentiality of participants' personal information. Please note that while your name will be recorded with the data, it will not be used in the report. All identifiable data will be stored securely on a computer with password-restricted access and only the researcher (and supervisor if applicable), and ethics committee members will have access to it. All identifiable information will be destroyed at the end of the study or after 15 years, whichever comes first.

If you decide not to participate there will not be any negative consequences. Please be aware that if you decide to participate, you may withdraw from the study at any time and your data will be returned to you or destroyed. You may also decide not to answer any specific question.

**What will happen to the results of the study?** The information collected from the participants will be analysed and included in a master's thesis which will be marked by an internal and external marker **Academic Research Information and Consent Form**

## Appendix 2: Questionnaire (adopted from Patterson & Arthur, 2009)

### Part A: Information about you

Please respond to the following questions. If you have additional comments about a specific question, print them in the space provided at the end of the question or questionnaire.

1)

What is your age? \_\_\_\_\_

2)

Sex:             male                             female

3)

What grade have you completed?

- 1  high school Grade 9
- 2  high school Grade 10
- 3  high school Grade 11
- 4  high school Grade 12
- 5  College or Institute Year 1
- 6  College or Institute Year 2
- 7  College or Institute Year 3
- 8  College or Institute Year 4
- 9  University Year 1
- 10  University Year 2
- 11  University Year 3
- 12  University Year 4
- 13  Other PLEASE SPECIFY:

\_\_\_\_\_

4)

What cultural traditions influence your decisions about health care? (**Check all that apply**)

- 1  Chinese
- 2  Canadian
- 3  Italian
- 4  Asian
- 5  British
- 6  Irish
- 7  Greek
- 8  African
- 9  Aboriginal
- 10  French
- 11  Thai

- 12  American
- 13  Native American
- 14  Norwegian
- 15  Argentine
- 16  Australian
- 17  Lebanese
- 18  Pacific Islander
- 19  Other \_\_\_\_\_
- 20  No Influence

5)

What religious traditions influence your decisions about health care? (**Check all that apply**)

- 1  Muslim
- 2  Judaism
- 3  Catholic
- 4  Buddhism
- 5  Anglican
- 6  Mormonism
- 7  Islam
- 8  Hinduism
- 9  Christian Science
- 10  Jehovah's Witness
- 11  Spiritualism
- 12  United Church of Canada
- 13  Other Christian denominations
- 14  Other \_\_\_\_\_
- 15  No Influence

• 6)

In general, would you say your health is:

- 1  excellent
- 2  very good
- 3  good
- 4  fair
- 5  poor

### **Part B: Therapies and providers that you have used**

• 7)

Do you use traditional medicine for: (**Check all that apply**)

- 1  preventing illness
- 2  treating illness
- 3  promoting health
- 4  I have *never used* TM

- 5  Other \_\_\_\_\_

If you answered that you have **never used TM**, skip to **Part C**.

• 8)

Identify the statement that best describes your health care practices:

- 1  I use TM only
- 2  I use TM with treatments given to me by my medical doctor
- 3  I use medical doctors only

• 9)

Which natural health products and therapies do you use or have you used in the past? (**Check all that apply**)

- Spiritual Healing
- Herbal medicine
- Vitamins and minerals
- Other \_\_\_\_\_

• 10)

Identify the statement that best describes your intake of natural health products. A natural health product includes *vitamins and minerals*. (**Check only one box**)

- 1  I do not take natural health products
- 2  I take natural health products on a daily basis
- 3  I take natural health products on a weekly basis
- 4  I take natural health products on a monthly basis
- 5  I take natural health products once a year
- 6  I take natural health products less often than once a year
- 7  Other \_\_\_\_\_

• 11)

Identify the statement that best describes your level of involvement with a TMH provider. (**Check only one box**)

- 1  I do not see TM providers
- 2  I see TM providers on a daily basis
- 3  I see TM providers on a weekly basis
- 4  I see TM providers on a monthly basis
- 5  I see TM providers once a year
- 6  I see TM providers less than once a year
- 7  Other \_\_\_\_\_

### **Part C: Your beliefs about TM use**

**In this section, young adult is an individual between the ages of 15 and 21 years of age.**

Listed below are a number of statements concerning your beliefs about TM use? For each statement you should circle the number that corresponds most closely to your belief. **Circle only one number. Please do not miss any statements.**

		<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Haven't decided</b>	<b>Agree</b>	<b>Strongly agree</b>
1	TM providers give good information on maintaining a healthy lifestyle	1	2	3	4	5
2	There are less side effects when taking natural remedies	1	2	3	4	5
3	TM involves natural plant formulas which are more healthy than taking drugs given by the medical doctor	1	2	3	4	5
4	people would be more likely to use TM if it was available in the mainstream health	1	2	3	4	5
5	people are more empowered when using TM because TM providers involve them in decisions about their health care treatments	1	2	3	4	5
6	people believe that TM builds up the body's own defenses and promotes self-healing	1	2	3	4	5

		<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Haven't decided</b>	<b>Agree</b>	<b>Strongly agree</b>
7	The more knowledge a person has about TM, the more likely he/she is to use it	1	2	3	4	5
8	Parent(s) and family can influence a young adult's TM use by exposing them to it	1	2	3	4	5
9	people are more likely to use TM if their friends are using it	1	2	3	4	5
10	People are more likely to use TM if coaches and teachers discuss it with them	1	2	3	4	5
11	people who believe in the physical, mental and spiritual aspects of health are more likely to use TM	1	2	3	4	5
12	people who fear the discomfort of treatments from medical doctors are more likely to use TM	1	2	3	4	5
13	I believe that taking TM therapies is not harmful	1	2	3	4	5

## Section E: Herbal Medicine Use

19. Do you use herbal/traditional medicine? Yes No

20. Why do you use herbal/traditional medicine?

- You were disappointed that conventional medicine is not working
- Conventional medicine is too toxic or too mutilating It is in keeping with your beliefs and your inner self It allows you to relax/sleep
- It relieves the symptoms of conventional medicine you are receiving It improves your psychological/emotional well-being (hope, optimism)
- It improves your physical well-being
- You believe that some illnesses cannot be cured with conventional medicine
- \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. How often do you take/use of herbal/traditional medicine? Daily Twice a day  
Occasionally Once a week Twice a week As needed Monthly Other (Specify)

\_\_\_\_\_  
\_\_\_\_\_

23 what conditions are you using herbal/traditional medicine for? .....

.....

24. In what form are you taking the herbal/traditional medicine? Tea Powder Tincture Tablet/  
Capsule Ointment Other  
(Specify) .....

25. Have you ever told your healthcare provider about your use of herbal medicine? Yes No  
If no, why  
not? .....

.....