Health and Religion: a Study of Health-seeking Behaviour in Kayamandi, Western Cape in the Context of "Medical Pluralism."

by

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the works, of other people has been attributed, and has been cited and referenced.

Signature Date

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CONTENTS

CHAPTER 1: CONCEPTUALIZATION AND THE STATEMENT OF THE RESEARCH PROBLEM

CHAPTER 2: MEDICAL PLURALISM: RESOURCE OR HINDRANCE

CHAPTER 3: FINDINGS

CHAPTER 4: COMPETING OR COMPLEMENTARY WORLDVIEWS

LIST OF TABLES

Abstract

This small-scale study explores the concept of medical pluralism by looking at the health-seeking strategies of a selected group of residents in Stellenbosch's Kayamandi township. The study addresses the following three primary research questions: What are the health-seeking strategies of the target group? What factors significantly influence their health-seeking behaviour; and why are the respondents using more than one health-seeking strategy? We have used theoretical formulations derived from literature together with data we collected by questionnaires and interviews to respond to these questions.

Our target group consisted of a mix of *isi*Xhosa-speaking Christians, which fall into one of the following three groupings: Ecumenical, African Independent Zionists, and African Independent Non-Zionists.

We applied a variety of methods to collect our data namely: survey questionnaire, in-depth interviews and a focus group interview. Basic statistical and qualitative analysis techniques were used to analyze the data. We tested various potential variables before we concluded that Christian affiliation and gender are two major variables in this study that seem to influence our respondents' choices of strategy.

The resulting data indicated that almost all of our respondents are mixing health-seeking strategies. They are mixing in two ways: either in a complex way (multiple health seeking strategies for a single ailment), or a simple way (different strategies for different ailments). Even though Western Medicine is a dominant and the only legalized health-seeking strategy in South Africa this research suggests that there is a growing use of other health-seeking strategies, either alternatively or complementarily to Western Medicine. Reasons for this are discussed in this research report, and include firstly, conviction of experience and knowledge of health and illness among others. Secondly, we have established that these determinants transcend accessibility and availability of, particularly, Western medicine facilities. Respondents utilize three different health-seeking strategies selectively through 'border crossing' with minimal conflict.

The dissertation argues that medical pluralism is probably a world-wide phenomenon and manifests itself differently in different contexts. We have also differentiated between two meanings of medical pluralism, and discussed the limitations of the concept. The results challenge public health policy makers to consider and acknowledge health-seeking behaviour/practices of black people, and mobilize and exploit the cultural and religious assets they have for dealing with illness. It also exposes the strengths and weakness of each health-seeking strategy as understood by the people living as they are in "two or more worlds".

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CHAPTER 1

Conceptualization and the Statement of the Research Problem

1.1 Introduction

This study has two primary objectives. The first is to document the health preferences and practices of a group of South African township dwellers. The second grows out of the first: to explore empirically some of the problems associated with the mixing of healing systems, more formally known as "medical pluralism". This second part of the study looks at how science and religion come together in health-seeking behaviour in modern Africa, using the township of Kayamandi in Stellenbosch, Western Cape as the area of study. The notion of medical pluralism will also be considered as a concept.

There are three dominant health/healing systems that township dwellers turn to when ill. The first is conventional western scientific medicine, the second is traditional African medicine and the third is faith healing of the sort found in the African Independent Churches. Jansen (2001) refers to parallel existence of multiple healing systems as "medical pluralism".

This study describes both the positive and negative consequences of medical pluralism. Township dwellers may draw on any one of the three healing systems when they are ill, but it is common for Africans to use two or more simultaneously in response to a single illness. This is not a problem if one practice complements the other in dealing with a particular illness, as for instance when a person with cancer goes to the hospital for medical treatment and also believes in the power of prayer and positive thinking. Ngubane (1981:369) explores some cases of such complementarity when she argues that "a diviner may recommend a combination of western and indigenous treatment. Thus the patient may be told to visit the hospital and then make a sacrifice to any ancestors who are angry at something - an act of omission or commission; or perhaps to consult the diviner again or visit the regular family

inyanga to obtain treatment for the 'African form of disease' while at the same time getting attention at the hospital for the *physical* ailment, such as by undergoing an operation".

However, medical pluralism is problematic when one healing system works against another. There are instances, for example, of Africans being treated for anxiety and being prevented from performing traditional rituals, which for them would address the sources of the anxiety. When allowed to perform the traditional rituals, they experience relief.

One also hears of children with diarrhoea whose parents ignore the clinic's advice and use herbal remedies prescribed by traditional healers, resulting in further dehydration requiring hospitalisation for an exacerbated more serious condition.

There are also instances of people being treated by medical doctors for brain tumours because of their strange behaviour and unusual dreams, while the problem is attributed to the 'calling' (Ukuthwasa*)* from the ancestors to be a traditional healer. Those who accept their 'calling' are said to experience relief from their symptoms.

It also becomes a problem when people do not disclose complementary treatments to health practitioners, whether medical doctor, traditional healer or faith healer. Some treatments can be harmful to patients when they are mixed.

This chapter unpacks the research problem within a theoretical framework and spells out how data is to be collected and analysed. A number of ethical issues are also considered, concluding with discussion of the value of the study.

1.2 The purpose of the research

In order to locate the complexities of the health practices that concern me I will briefly describe the local context of Kayamandi in Stellenbosch. I will expose the existence and the role of "religious health assets" (RHAs) in this local context. In

Cochrane J. R., (2003:02), a lengthy definition of religious health assets is given: in brief they "constitute a type of endogenous resource that may be leveraged for dealing with health crises as part of public health policy and practice". RHAs constitute religious experience, commitment and engagement through structural practices like healing movements and practices of the traditional healers, as well as the more familiar religion-based hospital or clinic. They refer therefore not just to material assets, but also to human, cultural, social and spiritual assets.

Kayamandi Township is typical in that the health-seeking practices of its residents are pluralistic; its people face a multiplicity of choices of healers and medical practices. For the purpose of this research, however, choice is not the issue; the issue is people's behaviour and practices in a "medically pluralistic society". Firstly, my hypothesis is that people are mixing healing systems instead of, and in preference to choosing one. Secondly, people's understanding of illness, and the way they respond to it, is informed by their culture and religion. It is also informed by the conceptual framework and knowledge they have regarding other healing systems to which they are exposed. As a result, despite South Africa's dominant biomedical institutions, "people's everyday health- and/or medicine-related behaviour does not necessarily conform to the bio-scientific conceptualization of modern Western medicine" (Lee 1996:31).

This research aims to investigate why people choose to use other health care systems alongside, or to the exclusion of, the dominant biomedicine. Apart from biomedical diagnosis and treatment there is a religious aspect, a traditional knowledge that people take seriously when they seek to understand, diagnose and treat illness. Traditional healers provide African religious explanations of and motivations for health and healing. From these explanations derive health-related activities like rituals, and the healers advise which ritual to perform for a specific malady.

Lee (1996:34) points to several explanations for pluralistic practice in Korean society[1]. He argues that "in medically pluralistic society each medical system

[1] We have relied on the material from other context like Korea, China and India to supplement what we have about Africa and medical pluralism due to the lack of adequate material.

provides unique treatment for distinctive set of illness for instance, biomedicine for acute illnesses and traditional medicine for chronic disease". This study will test Lee's argument in the context of a South African township.

Secondly, Lee argues, "each medical tradition is based on a distinct, internally coherent body of knowledge concerning diagnosis and treatment, and that the practice of physician of the different types of medical systems is an expression of that knowledge" (ibid. 35). This study will examine what other health care resources apart from biomedicine are available in Kayamandi and what they contributes towards health promotion and healing. It will look at how 'other' health knowledge, particularly that related to a religious worldview, is manifested in practice in Kayamandi.

Thirdly, Lee states "people's familiar traditional knowledge is modified and reproduced, but not replaced by experiences with new ideas and medical products". This study will examine that statement in the context of a South African township.

Some of the healing and health-related activities prevalent in this community are rooted in religion, particularly certain Christian practices. There are two primary sources of Christian health practices - the 'mainline' churches, and the African Independent Churches. According to the South Africa Year Book (2002/03:05) "the largest grouping of Christian churches in South Africa is the AICs, and one of the most dramatic aspects of religious affiliation has been the rise of this movement". People in growing numbers utilise African Independent Churches (AICs) for healing. Scholars like Bate (2001:361) argue that one of the main reasons why people join African Independent Churches in South Africa is that healing is provided.

AICs and mainline churches both give support, love and care when one of their members is faced with illness. Furthermore they help families, through prayer and Bible studies, to cope with illness and death. However, AICs also use holy water and certain enemas to fight diseases. Some people may be members of one of the mainline churches and yet also use a faith healer (*umthandazeli)* from one of the AICs. When people are sick they usually go to a clinic or medical doctor but also attend evening

daily prayers and possibly use the provided medication of the clinic and doctor, or the *umthandazeli*, or both. In an article on Clinical Practices and Organization of Indigenous Healers in South Africa, Ngubane (19981:374-5) concludes by arguing that "in view of the recent hostility towards the diviners in official and Western-oriented medical circles - which has fostered some clandestinity among the diviners and the clients - there is a need for careful and extensive research to ascertain how Africans, especially those in town, these days go about meeting their health needs. It would be most inadvisable to take any immediate steps to remedy the neglect and scorn of traditional medicine without first doing the utmost to obtain as precise and reliable a comprehension as possible, sensitive to major nuance, of the present state of indigenous practices and of the activities of its imitators and others who seek to profit from its continuing popularity".

1.3 Social context of the research

Kayamandi is in Stellenbosch, Western Cape; since 1994 little has changed in housing and infrastructural development. Kayamandi has approximately 29 000 inhabitants. The larger number of Kayamandi inhabitants are housed in an area of overcrowded squalor. Since 1994 there has been a major influx of new residents, particularly from the former Transkei and Ciskei regions, looking for employment and schooling. As a result, Xhosa is the predominant language, but Afrikaans, Zulu and Sotho are also represented.

Perdu (2002), in a study of Kayamandi, notes that according to a survey utilising a 10% sample, there are at least 22 000 people living in Kayamandi, excluding hostel dwellers (who had not been surveyed). But the number of hostel dwellers is estimated at 7 000, which means that there are at least 29 000 people living in an area of approximately 1 square kilometre. A more conservative estimate comes from the Stellenbosch Municipality which, according to Perdu found that Kayamandi has a total population of more or less 20 000; still an indication of the high population density and overcrowding.

According to Perdu's paper, the inadequate informal shacks occupy 70% of the surface and house 62% of the residents. There are about 2 000 informal shacks in Kayamandi, most of which average 3 x 3 m of floor space and house on average five to seven persons. There is no running water inside the shacks and one tap on the roadside serves six households. 85% have access to electricity. 23% of the families live in hostel accommodation where each family has approximately 6 square metres of family space generally open to the view of the other occupants of the hostel. These hostels were originally constructed as single men's quarters for migrant workers 30 years ago, and are badly in need of repair. Nowadays there can be up to 20 families in one hostel, often without baths or showering facilities, and no more than two toilets. Only about 15% of the total population live in formal housing. This overcrowding and poor infrastructure has resulted in unhygienic and unhealthy social and environmental conditions and consequent susceptibility to opportunistic diseases.

Recently there have been a number of positive interventions in the development of the township. These include a multi-purpose community centre, established by reconstructing an old beer hall. The centre is utilised for training, workshops and other youth and community activities. The centre also provides soup for the unemployed, homeless, children and aged of the community. The leading organisation in the establishment and maintenance of this centre is Greater Stellenbosch Development Trust. Another centre, also recently created with the assistance of the municipality and a Stellenbosch church, provides space for crèches and a community hall. This centre also plans to provide drugs to people living with HIV/AIDS. A few meters away is an *Ikamva lethu* HIV/Aids resources centre run by Kayamandi Mobilization Community Project under Stellenbosch Aids Action. It provides information and condoms, and refers people to Stellenbosch Aids Action for counselling and testing.

Last but not least, there is Simanyisizwe Christian Community Project, a joint venture of youth in Kayamandi churches, particularly the mainline churches. They make use of their church structures for workshops, services and support group prayers. For the past two-years they have been promoting awareness and health, cleaning Kayamandi's streets and between shacks. There is now another group cleaning the

streets and the heavily polluted Plankenburg River, the water of which is demonstrably toxic.

Conditions in Kayamandi are not conducive to good health. However the potential is there for health promotion if resources can be mobilised, leveraged and effectively utilised. There are, for instance, religious health oriented assets for health promotion, health care and treatment. There is a need for acknowledgement of the role that each health asset can play in providing health services. There is a need for the establishment of a public health framework that will incorporate and utilise religion based health assets such that they complement rather than compete with conventional western medicine.

1.4 Conceptualization of the research problem

The first part of this study describes the health-seeking behaviour adopted by township dwellers in Kayamandi. The second part will gauge the extent to which people are using two or more health-seeking strategies simultaneously and the consequences for the individual and society of mixing these health systems. The study will also look at *why* people are mixing healing systems.

The following are concepts key to this study:

i. Health/healing/sickness

ii. Health seeking strategies

iii. Medical pluralism

1.4.1 Health, healing and sickness

The World Health Organization has proposed a view of 'health' "as not merely the absence of disease or infirmity, but a positive state of physical, mental and social well-being." (Shriver, 1981:10). This definition marries nicely with the traditional African view about health, which Dawes (1996:76) describes as the harmonious relationship between the individual and the natural environment, with the ancestors,

and with other community members. Rather than being narrowly defined realms, the social world (which includes the spirit and the living) and natural world are united within a larger cosmological universe. Pillay (1996:7) in a study conducted in Durban found that the urban black person's conception of health and illness is holistic. He says, "Health is viewed as feeling good, well, comfortable, free in body and mind and involves the feeling of contentment with life. The individual's mood indicates that the person is well; there is no pain; the individual is active and productive; there is normal vegetative functioning and the individual socializes appropriately".

In our study healing refers to the conquering of all the undesirable states of affairs in the condition of a human being. Healing includes dealing with the emotional effects of disease, going beyond the realm of physical symptoms to the root causes of illness. It means helping the infected and affected people to cope with the illness. The sickness of a single person in a family affects emotionally many others within the family. Coping and caring are crucial to the healing process.

In a review of one of Bate's books namely, *Inculturation & Healing: Coping-Healing in South African Christianity)*, Pilch (1996:206) differentiates between curing and healing. He points out that "the definitions and distinctions in medical anthropology between disease (organic and objective) and illness (social and subjective) and curing (restoring or maintaining organic integrity) and healing (providing human meaning to the sickness experience) would have sharpened Bate's discussion if he had adopted and applied them throughout the book rigorously and consistently". Given the nature of diagnosis and healing, we can argue that the African healing system is much more concerned with illness than disease, healing than curing; in the process of understanding sickness it focuses on communication and interpersonal interaction, particularly within the context of family, social network and the living dead.

With regard to health and healing, Saayman (1999:215) comments from a specifically religious (Christian) perspective: "I understand healing in a comprehensive way, as the involvement with Jesus of Nazareth in [his] victorious encounter ... with everything that diminishes our humanity, the powers of evil, the various contemporary idols of death". Healing thus means much more than conquering a

disease; well-being means much more than simply the absence of a (mental or physical) disease.

Sickness is deeply embedded in many other issues; physical symptoms are just effects. In the African worldview, for instance, some diseases are understood to be symptoms of disorder in a state of equilibrium brought about by misbehaving or neglecting ritual performances or maltreating the ancestors. If one does not perform the appropriate rituals there is a likelihood that the illness will persist. Saayman (1992:43) mentions two issues pertinent to healing in an African worldview.

Firstly, he states, "according to the traditional African view, healing is a thoroughly religious phenomenon". He then quotes Goba who said that, "according to the African religious cosmology [it is] the failure to communicate with the ancestors, 'the living dead' [which] brings about illness or suffering". He goes on to state that; "a second very important dimension to the African view on healing which is linked very closely to the first is that a person can only be healthy if she belongs to a healthy community". In relation to this state of equilibrium Oosthuizen (1989: 30) contends that, the aim of health-seeking is to restore equilibrium and to restore the balance of communication and communion with the ancestors through the performance of whatever rites, rituals, ceremonies and sacrifices are required.

1.4.2 Health-seeking behaviour/ strategies

According to Holmes (1999:65) "Health behavior refers to all those things humans do to prevent diseases and to detect diseases in a symptomatic stage. In contrast illness behavior refers to all those activities designed to recognize and explain symptoms after one feels ill, and sick role behavior refers to all those activities designed to cure diseases and restore health after a diagnosis has been made".

Illness behavior is the diagnostic stage of healing. Pillay (1996:07) refers to this stage as "the stage of alertness"; he suggests that during the stage of alertness the individual tries to understand or attach meaning to the symptoms. In addition to the views of others, the individual's beliefs and past experiences will also play a crucial role in

establishing meaning for the symptom. The concepts of sick-role behavior, health-seeking behavior and help seeking behavior share the same meanings and may be used interchangeably.

These concepts form a stage during which an individual acts on the basis of a diagnosis. Stock (1992: 279) argues that "the utilization of formal health care service is part of the larger category of health-care behavior".

"Health-care behaviour may be defined as a process through which a person, who perceives himself or herself to be ill, chooses and implements strategies to facilitate the restoration of health"(Holmes 1999:66). Strategy in the context of health-seeking behaviour means that people are repeatedly behaving in a particular way when confronted with a particular illness. Although it is not always conscious, it is nevertheless has a certain consistency. Probably it is not as conscious as the word strategy seems to suggest. Strategy, in this context, is how people go about solving the illness/health related problems, which they face.

1.4.3 Medical Pluralism

Though formally South Africa has one 'official' health system (biomedicine), South Africa's medical framework is "pluralistic" in that it provides people with a multiplicity of choices of healers and health systems. Ngubane in Pillay (1996:01) notes that for "blacks in South Africa, alongside the western medical system exists an old traditional system of healing and health care. Their cultural and social beliefs have shown to contribute to the way they conceptualize illness and disease and use health care facilities. Traditionally, they view illness in terms of natural, moral aetiologies".

Plurality of medical practices means the existence of several health/healing systems in one social context. Jansen (2001:70), in relation to medical pluralism, cites Bhardwaj's (1980:209) observation that "in the current literature medical pluralism is defined as the synchronic existence in a society of more than one medicine system grounded in different principles or based on different worldviews. Pluralism describes

a situation in society where choices can be made between several competing models, values and religion".

Pluralism implies the existence of more than one competing model. Those needing health care are faced with multiple choices, complicated by what Jansen (2001:70) terms "plurality in people's conception of health and illness". It is not unusual for separate individuals to conceive of the same ailment differently, and thus choose different paths when making treatment decisions. Others draw on more than one health systems in response to a single ailment.

Lee (1996:31) studied the existence of multiple therapies from diverse medical traditions among Koreans. He noted that, though biomedicine is dominant, people's practices and behaviour do not conform to biomedicine alone. He observes "...the pluralistic medical setting of Korean society provides a context in which people easily incorporate conceptual frameworks and frameworks from different medical traditions into their own perception of health and medicine". The way people conceptualize illness and disease is very important in shaping how they respond to illness and where they seek health care. The choice and practice of health-seeking strategy is influenced by a variety of factors.

In the findings of a study conducted among urban black people in Durban, Pillay (1996:08) notes "help-seeking may be separated into four broad areas, namely, self-help, prayer, cultural and medical". She further stresses that, "it is important to note that the various sources of treatment [offer] not necessarily mutually exclusive treatments. Individuals tend to use them concurrently. However, certain treatments may be more socially sanctioned than others".

According to Lee, societies like these are 'medically pluralistic' and offer treatments from different health systems, e.g. biomedical & traditional, for different categories of illness. There could be lessons for the South African health care services from the Korean experience of medical pluralism.

Jansen (2001:69) identifies "three 'streams' found in Africa: Western scientific medicine, African ethno-medicine, and the healing ministry of African Independent Church (AICs)". These three dominant health systems will be discussed below.

1.4.3.1 Conventional Western medicine

Traditional Western medicine is a science-based approach to healing which is generally evidence-based as well. The approach uses scientific parameters to define and evaluate information and results; in a sense nothing is meaningful unless it can be seen, heard, touched, smelled, tasted or measured. This form of health care/strategy is provided primarily by medical scientists, medical workers (doctors, nurses, laboratory technicians etc) and state health departments.

Proponents of biomedicine believe that one simply cannot do without science; they thus believe that to understand disease processes such as symptoms, diagnosis and treatment, science is essential. For medical practitioners in Africa there exists a dichotomy between science and culture. Science does not understand health and healing the way that African culture understands it.

Critical analysts of anthropological studies, in particular around biomedicine, argue that it is reductionist in the sense that it objectifies the patient and the disease. "Disease is thus entified and treated as a dimension of human biology rather than as socially produced misery or human suffering" (Good, 1993:82). This form of health system de-contextualizes the patient; the healing process does not take into consideration the context (beliefs and values) of the patient. Western medicine is reductionist in the sense that for its practitioners the individual is the object of medicine. The individual is regarded as the problem, so that diagnosis and treatment focus solely on an individual as a problem.

Western medical practices were introduced to Africa and provided by missionary churches. Jansen (2001:71) says that these mission hospitals were not widely supported by the African people, and that "only patients discontent with the work of the traditional practitioners chose the mission hospitals as their last resort". It is

important to note that this is no longer the case; indeed, the opposite may be happening.

1.4.3.2 African traditional healing

Traditional healing is the classic, ancient African way of understanding health and illness using indigenous beliefs, diagnosis and treatment. Ngubane (1981:366) distinguishes between two main kinds of indigenous healers: those who provide diagnosis and/or treatment, and those who provide treatment alone. The first are the *inyanga* (Zulu) or *ixhwele* (Xhosa). This healer is male, uses African medicine and has no clairvoyant powers. The second is the *isangoma* (Zulu) or *igqirha* (Xhosa), usually female, who has clairvoyant powers as well as a comprehensive knowledge of African medicine. Scholars seem to agree that this form of health care understands human beings holistically, meaning that healing is based on healing the whole person, spiritually, psychologically, physically and mentally.

Ngubane (1981:368) states that this health system has "an effective view of the patient as a complete person rather than an example of a particular disorder, as well as a disposition to regard the work of other kinds of medical practitioners as complementary to their own". In the South African context it is an unofficial health care service. Van Rensburg (1992:312-313) noted that "while allopathic health care in South Africa - and for that matter in most societies worldwide - constitutes the dominant and official form of health care, it definitely does not constitute the total health care supply. The official health care supply in South Africa is also supplemented by a significant non-official, alternative care supply of which African traditional care is but one category in which it is manifested".

1.4.3.3 Faith healing

According to Van Rensburg (1992), faith healing is one of the unofficial modes of health care in South African. I will focus on one group of healing churches. The African Independent Churches make up the largest grouping of Christian churches. "There are 4,000 or more African Independent Churches, with a total membership of

more than 10 million. Although these churches originally were founded as breakaways from various mission churches (the so-called Ethiopian churches), they are now primarily Zionist or Apostolic with some Pentecostal offshoots" (International Religious Freedom Report, 2002:01). The prophet or prayer healer, *umthandazeli* in Xhosa plays a crucial role in these churches. Oosthuizen (1989:31) states that "according to Martin West (1975), these churches attract members primarily because they promise and provide healing for the physically and mentally ill. They had their origin in the Mission churches and some remained close to the original church but others incorporate many traditional beliefs and practices. These churches practicing faith healing believe primarily in the power of God. In the Zionist-type churches, with bishops and prophets, the belief is in the power of God and the guidance of the Ancestors".

Froise (2000:76-82) in Bate (2001:361) also note that "the largest group of Christians in South African belongs to churches which focus on healing of one form or another. According to the 1996 census this group comprises about 45% of all Christians and 51% of Black Christians". Jansen notes that "...the issue of healing plays a dominant role among the reasons why people join AICs". Healing is the major aspect of their religious life.

Faith healing occurs through prayer rather than through medicines, physicians or traditional healers. Prayer, faith, and other spiritual means are at its core. Faith healing emphasizes God and the Holy Spirit as crucial to healing. Bate (2001: 363) calls these "coping-healing churches". He differentiates between two types of coping-healing churches: "African independent churches operate within the parameters of acculturation between African tradition, Urban Black working culture and traditional Christian practice and the Charismatic/Pentecostal type which operate within the Pentecostal tradition and incorporate elements of Postmodern culture, especially those related to the media and entertainment industry" (2001:363).

1.5 Medicine or Healing

These two concepts are common in this study and it seems appropriate to give a rationale for referring to the 'Western' scientific way of curing a disease as "medicine" and African and faith ways of dealing with illness as 'healing'. Western medicine is the common term to refer to scientific medicine. Healing is also a common term in Africa used in association with African and faith related practices. It does not only refer to *u'Muthi'* (medicine) but to the whole system of healing and practices. It refers to other complex practices, beliefs and activities that are not medicinal.

1.6 Psychic and Psychological

Psychic illness we define as mental illness like spirit possession, illnesses that are believed to be caused by witchcraft or ancestral dissatisfaction and others. We assume that most African people adopt traditional healing and faith healing when faced with illnesses falling in this category. This therefore fits well with our concept of medical pluralism, as we endeavour to establish the pertinence of the African worldview during sickness in our population of study.

Psychological illness is stress and anxiety related illnesses and we assume that most people believe that the best strategy to treat them is Western medicine.

In the four categories of illnesses that we have identified (Serious Physiological illness, Mild Physiological illness, Psychological illness and Psychic illness) the two that we have discussed above are related because they are more emotional than physical, though at a certain stage physical correlates may become evident.

1.7 Research methodology

1.7.1 Introductory note

This section of this chapter describes how data was collected and analysed in order to answer the research questions that drive this study. These research questions are:

i. What does the target group do to get well when they are sick, i.e. what health-seeking strategies does the target group adopt? Here we are interested in the choices and preferences of the target group.

ii. Why do some members of the target group use more than one health-seeking strategy to address a sickness? This is a question about medical pluralism.

iii. What factors influence the way people behave when faced with illness / sickness?

The data was collected using both qualitative and quantitative methods. We started with a survey questionnaire followed by semi-structured face-to-face individual interviews, and ended with a focus group interview. In addition to the survey it seemed appropriate to use qualitative methods because we wanted to explore the reasons why they mixed health-seeking strategies and what problems they experienced when mixing these strategies with some of the respondents. The qualitative methods we used provided us with further insights from the respondents' point of view. This reflects Babbie and Mouton's (2001:53) view that qualitative research enables researchers to study human action from the insiders' perspective.

When we asked the question about mixing health seeking strategies we did not anticipate that people would understand mixing health seeking strategies differently. We understood mixing as using more than one strategy for a single ailment. However, findings show that our respondents understand mixing in two different ways: firstly, the way we anticipated -- that of using two or more different strategies for a single ailment; and secondly, mixing as using different strategies for different types of ailments. This is taken into account in the analysis of results.

1.7.2 Population and Sample

We employed a purposive sampling technique. In purposive sampling "the researcher uses his or her own judgment about which respondents to choose, and picks only those who best meet the purposes of the study" (Bailey, 1982: 99). Similarly, Babbie and Mouton (2001:166) say of purposive sampling, "[s]ometimes it's appropriate for you to select your sample on the basis of your knowledge of the population, its elements, and the nature of your researcher aims: in short, based on your judgments and the purpose of the study". This best describes our non-probability sampling technique.

The target population was Xhosa-speaking black people residing in Kayamandi who profess to be Christians. The dominant groupings of Christians in Kayamandi are Zionist African Independent Churches (Pentecostal), Non-Zionist African Independent Churches (AIC) and Ecumenical/Mission denominations. Ideally we wanted an equal number from each of the dominant groupings but in the end, due to time constraints, we settled for those to whom we had ready access.

The total number of respondents in the survey was 35. They were divided as follows: nine Zionist, eight Non-Zionists (AIC) and 18 Ecumenical/Mission. Almost half of the respondents were from Ecumenical/Mission churches because they were more accessible to the researcher. We also ensured that there was a mixture of younger (18-35) and older (36+) respondents, and men (15/35) and women (20/35).

Obviously such a small sample was not representative of the target population, and it can carry no general statistical significance in terms of the target population. But it gave us the opportunity to test our research instruments and to discover patterns in the data that in turn have given rise to a set of interesting questions. This clearly places severe limits on the general empirical value of the present study, but it also lays the foundation for a larger scale study.

1.7.3 Methods of gathering the data

1.7.3.1 Questionnaire Survey (Refer to Appendix A, page 105)

We used a questionnaire initially because we wanted to identify among the respondents those who mix healing strategies, which was central to this study. We first piloted the questionnaire with a few selected individuals. Our decision to pilot the survey instrument proved to be useful because this led us to refine the questionnaire by making a number of changes and adding some questions.

It is important at this stage to describe briefly the rationale for each of the questions posed in the questionnaire in order to make clear the underlying research purpose in asking these questions. The questionnaire itself is reproduced as Appendix A.

Questions 1 to 15 were demographic questions. The first question asked for a place of birth. We asked this question because we wished to establish whether there was a relationship between categories (rural or urban) of birthplace and the type of health-seeking strategies (Western Medicine, Traditional Healing and Faith Healing) adopted by respondents.

A second question asked for the age of respondents. We asked this question because we postulated a relationship between age category and health-seeking strategies. Given that we have argued and verified that people are located in the context of medical pluralism, we were interested in discovering whether health choices and preferences differ according to age groups.

The third question concerns duration of stay. It is important to know when people arrived in the Cape Town area to explore the possible relationship between length of stay in the urban area and health-seeking strategies.

The fourth question asked about whether or not the respondents viewed metropolitan Cape Town as their home. We asked this in order to try to identify possible

relationships between the respondents' identification with Cape Town (as an urban area) and their health-seeking strategies, because we suspect that this impacts upon the extent to which they are influenced by a western/urban worldview, which includes western medicine.

The fifth question asked those who do not view Cape Town metropole as their home where "home" is. We wanted to be able to assess how those for whom Cape Town is not home behave when they are sick, and whether this mark of "home place" influences their choices and preferences. The sixth question asked about gender, for the same reason.

The seventh, thirteenth, fourteenth and fifteenth questions were all linked to concerns regarding the sample. We asked these questions to establish whether our research was in line with the sample design. These questions ensured that the people we needed for this study were in fact included. Most black townships are constituted by people from various language groups and Kayamandi is no exception; however, Xhosa is the dominant home language. For the purpose of this study we chose to focus only on Xhosa-speaking people. This seventh question was included to check that the respondents fitted this sample criterion.

Questions thirteen to fifteen ask the respondents whether they would identify themselves as Christians, what they call their church, and in which Christian grouping they would classify their church. In this study we are interested in Christians. Firstly, Christians constitute the majority of all South Africans and in Kayamandi they are by far the biggest faith group. Secondly, we have identified faith healing among Christians as one of the primary sources of health-seeking behaviour in South Africa and it was important to get representation of this phenomenon in our study. Finally, we asked about Christian groupings to investigate whether the respondents' health-seeking behaviour differed according to their Christian grouping.

"What other languages do you speak?" was asked in order to determine whether there is any relationship between an ability to speak other languages and respondent's health-seeking behaviour. They are likely to have learnt Afrikaans while working on farms in the Boland and therefore were probably exposed not only to the language,

but also to Afrikaans culture, which is strongly influenced by Calvinism. We also suspect that those who speak only Xhosa are more likely to be sympathetic to traditional healing and faith healing, which are both prominent healing strategies historically adopted by Xhosa-speaking people living in the Eastern Cape.

The ninth, tenth, eleventh and twelfth questions all concern class and level of income. We asked these questions because we wanted to explore a possible relationship between economic status and health-seeking strategy.

Questions sixteen to twenty three are core sub-questions of the main research question. These questions concern the health-seeking behaviour of the study population. These questions were also asked because we seek to establish if our respondents are using more than one strategy, and under what conditions or circumstances they mix strategies. For the purpose of this research we focussed to those people who are mixing health-seeking strategies.

These questions were designed to determine what strategies the respondents adopt for various types of sicknesses, which we have grouped as follows: Serious physiological illness, Mild physiological illness, Psychic illness and Psychological illness. The two latter groupings are both psychological, and though they both manifest themselves physically, they are different. Differences between Psychic and Psychological illness were discussed earlier in the introduction.

Questions sixteen to twenty three are asked to clarify whether or not the heath-seeking strategies used by the respondents are consistent across the different types of illness. While questions sixteen to nineteen asked respondents which strategies they would choose for themselves when they are sick, questions twenty to twenty three were asked to test whether or not health-seeking strategies that the respondents encouraged members of their families to adopt were consistent with their personal choices. We asked these (20-23) questions to see how strongly respondents felt about the strategies they were using and the extent to which they believed family members should adopt similar strategies.

The twenty-fourth question asked those who indicated that they used multiple health-seeking strategies why they did so. We wished to know why these respondents adopted more than one health-seeking strategy: whether it was for different categories of illness or for a single category. This question was central to the study.

The twenty-fifth question, asked those who were mixing different health-seeking strategies how they went about mixing in practice. In addition to an attempt to expose about the different ways in which the respondents mixed, we wished to reveal how they understand the concept of mixing health-seeking strategies.

The twenty-sixth question asked those respondents who were mixing health seeking strategies where they choose to go first to seek help, and why. We asked this question because we hoped to establish which strategy they adopt first and why they adopt it first.

The twenty-seventh question asked the respondents whether or not they think mixing health-seeking strategies is helpful. At another level this question was asked to contribute to the major question of this research: why people are using more than one health seeking strategy.

The twenty-eighth question asked those respondents who were mixing health-seeking strategies if mixing helped them. This question is similar to the question above. However, it probes beyond question 27 by asking how often mixing helps those respondents, if it helps at all. The difference between questions 27 and 28 is subtle: question 27 is more general and abstract whereas question 28 is more specific and personal.

The twenty-ninth and last question asked those respondents who were not mixing health-seeking strategies to state their reasons for not mixing. This question was linked to question 24. We asked this question as an attempt to understand why those who are not mixing health-seeking strategies are not doing so.

These questions were designed firstly to help us document our respondent's choice and preferences when they are sick. Secondly, they were designed to help us respond

to the basic questions (as listed above) of this research, and in that way help us see if our research supports or contradicts our hypothesis, and the theoretical framework we have developed.

1.7.3.2 In-depth Interviews

The questionnaire survey was followed by individual face-to-face interviews with selected respondents who participated in the survey. Babbie and Mouton (2001:289) suggest that open-ended questions in interviews allow respondents to volunteer information rather than restricting their responses to a "battery of predetermined hypothesis-based questions".

The interviews were conducted in the respondents' mother tongue (Xhosa) in order to minimize misunderstandings and to increase the accuracy of the information collected. We subsequently translated the interviews into English. The interviews gave us the opportunity to further explore some questions asked in the survey and fill gaps in the data we had already collected. We explored questions such as why people are mixing, how they mix, and what problems are brought about by mixing healing strategies.

We also had an opportunity to observe the healing practices of the members of the St Johns Apostolic church, which is an African Independent Church (non-Zionist), and one of the largest Christian denominations in Kayamandi. We had a focus group discussion with eight of the members who had participated in the healing service. The focus group discussion lasted about an hour. Half the participants in the focus group interview had previously completed the questionnaire.

This focus group helped us "to get insights into people's shared understanding of everyday life" (Gibbs, 2003:02). Secondly, this focus group helped us "draw upon respondents' attitudes, feelings, beliefs, experiences and reaction", which we believe are crucial in a study of this nature (Gibbs, 2003:02).

We record briefly here how we went about doing the survey in the field. We attended church services and after introducing ourselves to the congregants we asked those who were willing to help and participate in this study to remain after the service. We also approached a teacher of basic languages and mathematics to give us a slot in one of her classes. At one stage it became necessary to visit certain individuals in their homes to request them to complete the questionnaire and to canvas their participation. Most of the survey was done using a self-administered technique.

1.7.4 Analysis of data

1.7.4.1 Survey Data

The survey data was analyzed by applying the following tools: firstly, all the data we collected was processed using a spreadsheet package (Microsoft Excel). Secondly, data was cleaned and then imported into a statistics software package (Statistica). We used Statistica to enable us to generate the descriptive statistics used in this report. The research questions mentioned above guided the basic statistical analysis.

1.7.4.2 Interview Data

In-depth interview and focus group notes will be used to supplement the questionnaire later. Our report is based largely on the survey data; focus group and in-depth interviews will be used as supplements.

1.8 Value of the study

The AIDS crisis in Africa has led to a number of suppositions. There is a growing recognition of the fact that traditional and faith healers can play a crucial role in the fight against HIV/Aids: firstly, it is believed that they provide a valuable support service for patients in remote rural areas of Africa; secondly, there is increasing evidence that some traditional healers can treat some opportunistic infections.

There is, however, considerable concern about certain unsafe practices of traditional healers and their claims that they can actually cure AIDS, which could rather increase the incidence of HIV/AIDS infections and deaths. This issue is ambiguous: Green raises the question "...if healers are engaged in practices detrimental to public health, don't health and government officials have a public health responsibility to try to change these practices rather than ignore them?"(1988:1127). This study will contribute to the understanding of people's preference and choices; this understanding can in turn help policy makers deal with medical pluralism.

Most significantly, this study is part of a larger separate project currently under development at UCT, a project aiming to mobilize, leverage and enhance African religious health assets in Sub-Saharan Africa. Thus, by addressing current issues, this study is a contribution to a part of the contemporary research agenda. This study examine certain issues pertinent to public health around the concept of "medical pluralism" to provide insight for African religious health assets as they relate to health-seeking behavior and practice.

1.9 Conclusion

In an era of HIV/AIDS and re-emerging epidemics, it is crucial that health practitioners from the different health/healing strategies work together. Only by co-operation can a health-care system be designed that acknowledges the practices of black South Africans and puts an end to unnecessary competition, which can only work to the patients' detriment. Health practitioners must forge co-operative working relationships that complement each other and, depending on the nature of the ailment, recognise each other's particular strengths. Religious based knowledge informs people's choices and preference when they are ill. There are religious based healing and health-related activities that people practice to get well or promote health. The health-care system therefore needs to recognise and utilise "religious health assets" in local communities like Kayamandi.

CHAPTER 2

Medical Pluralism: Resource or Hindrance?

2.1 Introduction

This chapter explores *medical pluralism* one of the more contested concepts in the study of religion and health, in Africa and South Africa in particular. The research with regard to the concept in South Africa, Africa and around the world both in its conceptual and practical aspects, will serve to provide the theoretical framework for our study. Pluralism is one of the key concepts in the postmodernist paradigm, as it has been generally accepted in democratic societies.

The concept of medicine as a practiced activity is also highly contested and paradoxical. Freeman (1979:277) argues that "'medicine' is an English word which identifies a European cultural and social domain". On the other hand Press (1980:45) states that "medicine ... is a term for a set of social practices by which man seeks to direct and control a specific group of natural phenomena ... which lower vitality and tend towards death." Both these definitions are problematic and limited; therefore we shall attempt to examine and problematize the concept.

It would seem constructive to abandon the term *medical pluralism* when we refer to pluralistic choices of health strategies; instead of "scientific medicine," a more appropriate term might be "scientific health strategy," because scientific medicine is one component of a broader health system. According to the definitions above and our conceptual understanding, medicine as a remedy in specific terms is only one of the possible responses to sickness. Other health strategies exist which transcend that limitation and look at health more comprehensively.

Minocha (1980:221) says, "Several studies show clearly people's manifest preference for modern medicine. They want a good curative service, and see prevention and promotion as secondary. The health administrators want people to reverse this order".

This chapter seeks to explore historical and contemporary understandings and assumptions around the concept of medical pluralism. In that process we hope to discover and develop new theoretical frameworks through which our idiosyncratic social context can be better studied and understood.

2.2 Significance of the context

The concept *medical pluralism* is contextual and it manifests itself differently at different times in different places. *Medical pluralism* is probably now a worldwide phenomenon, given that the context in which people live today is always pluralistic to a certain degree. How medical pluralism manifests itself does not only differ from country to country but can also differ within the same country between rural and urban populations.

It is therefore crucial, before we unpack the concept, that we should first describe the context of this investigation and its theoretical hypothesis. Not only will it help us to recognize which type of medical pluralism is operating within the context of our research population, but will also enable us to make assessment and reveal trends to facilitate projections of future condition.

The South African township context is particularly interesting for various reasons. Firstly, townships have a different lifestyle and culture, to which migrants from rural areas to the townships are forced to adapt. Secondly, township culture can be said to be hybrid in that it blends both western and African elements in higher levels that its rural counterparts. In this pluralistic context there is both competitive and complementary pluralistic knowledge about health systems. It is, for instance, commonly assumed that people in rural areas prefer traditional medicine over western medicine because it is easily available and accessible. But Minocha (1980:221) states: "People may rely on traditional practitioners when modern medicine is not available to them easily and adequately. This does not warrant the conclusion that they prefer traditional to modern medicine as some scholars and politicians claim". Thus research in an urban context where modern medicine is more accessible is likely to make options of accessibility and preference stand out more clearly.

2.3 Social reality

This investigation is framed by the view that most, if not all, African societies can be termed medically pluralistic. As Leslie (1980:191) says, "all medical systems can then be conceived of as pluralistic structures in which cosmopolitan medicine is one component in competitive and complementary relationships to numerous 'alternative therapies'". Similarly, Stock (1987:285) claims, "all people have some choice of therapeutic strategies, irrespective of where they live. In the Third world, the range of choice is usually very considerable, although the actual choices will vary according to culture and location". This is a social reality that we cannot escape from or disregard.

An issue of interest is whether this pluralism is problematic. It is a fact that, in spite of the amount of research, experience and effort that has been put into western scientific medicine, it has failed to provide solutions to all health problems. This study assumes that when Africans utilize other health care resources, it is because they are traditionally exposed to variety and equipped with competing, and yet complementary health knowledge.

This will constitute the basis of our exploration and clarification of the concept itself. Leslie (1980:193) puts the social reality this way: "…scientific medicine is composed of rules, categories and metaphors that are particularly effective for discovering and treating diseases, but even if unlimited funds were available to create the best system of scientific medicine planners could design, laymen would probably continue to resort to 'alternative therapies' because a central clinical fact of the way medical systems work is that they are social systems that give meaning and form to the experience of illness." According to this view, choice transcends accessibility and availability.

2.4 General background and historical manifestation

In the last generation there has been a resurgence of the so-called 'alternative' health-seeking strategies. These forms of healing are called 'alternative' therapies primarily because the western-type health care system has been given prominence over other

therapies. Historically, traditional African healing was dismissed by colonial forces: traditional healing practices were labeled as pagan and anti-Christian. "Modernization" and "enlightenment" came through government policies and Christianity, and African converts were required to do away with their traditional practices and conform to western ways.

Western scientific medicine was brought to Africa through colonialism and African people were forced to conform to medical traditions they were not familiar with. Given this historical expedition, western medicine and traditional medicine have been generally perceived as distinctive and contrasting. Good (1987:81) states that "prior to the 1970's, anthropological analyses of western medicine and physicians, picture biomedicine in terms of idealized contrast to traditional healing systems and traditional healers". This suggests that, since 1970, the understanding and knowledge about medicine and healing has changed.

African indigenous health knowledge is resilient and persistent, and thus has not been destroyed. It became apparent to people that western science failed to provide all the answers to contemporary health questions: "there has been a question about the level of effectiveness of modern medicine in alleviating the disease patterns in advance capitalist society" (Good, 1987:82). Western medicine has been perceived as the dominant system throughout the world. This view is superficial, in that it fails to view the matter comprehensively. In some instances, the dominance of the western health system is measured only by its legalization, institutionalization and its physical presence. There is danger in pursuing this view, because legalization or physical presence are not equivalent to medical usage.

It is important that we look critically at how medical systems derive their dominance. According to Press (1980:50) "dominance may be derived from several sources, among them traditional prestige or usage, political imposition and legalization ("officalization"), or prestige derived from usage by an elite population". He goes on to stress that "medical systems which derive dominance through local tradition would seem capable of serving the widest variety of medical and psycho-social needs".

On this basis the best way to measure dominance need not be institutionalization, legalization or political imposition, but rather medical practice or usage. We cannot assume that a certain health strategy is dominant; dominance varies according to geographical spheres of influence. Western scientific medicine might be dominant and widely distributed internationally or globally; however that does not necessarily mean it should be assumed to have "local" or "regional" dominance in terms of geographical standardized usage, practice and distribution.

2.5 Understanding medical pluralism: the inner core

The premise of this study is that people accumulate information and knowledge which governs their activities when they are faced with health issues. Pearce (1993:150) believes that in their attempt to respond and handle health matters, lay people freely use and integrate aspects of competing knowledge.

Pearce (1993:162) also states that: "At an intermediate level, the presence of various types of medical systems influences people's behaviour. Here we find both the serial and simultaneous use of competing systems. Aspects of faith healing and biomedicine can be used by one individual, while biomedicine and indigenous approaches are combined by others."

Health behaviour, practice and choice of therapy are heavily influenced by medical knowledge, and the presence of competing knowledge around health matters is a complex issue. Pearce (1993:151) provides a framework through which we may explore how health knowledge is generated, and how it influences people's health behaviour and practices. He rightly argues that "when confronted with a health problem, individuals and groups make use of and integrate societal/cultural factors (macro) with features drawn from the medical sector itself (intermediate) as well as the physical and psychological dimensions of their own experience (micro) to represent reality to themselves and others".

It is therefore argued that whilst socio-cultural factors are seen to be secondary by medical practitioners, they provide profound and useful health-healing knowledge for many.. In other words, although Western medicine might be eminently predominant, the social reality does not automatically conform to the predominance that it has been given. Its predominance is sometimes overstated, and based more on historical expectation than the current course of events. I argue that divergent theory and discourse are subservient to social reality

The concept of medical pluralism is not a social construct: rather it presents social reality. People are informed by their experience and knowledge which in turn determines how they interpret and respond to their health problems. For example, Pearce (1993:153) argues that "in south-western Nigeria the population can choose from a number of medical traditions to interpret their health problems. These include biomedicine, indigenous medicine and Islamic and faith healing". This practice is common in Africa, and this research will show that South Africa is likely to be marked by high levels of medical pluralism. The data on Khayamandi will provide evidence, and though this is a limited, single case with a very small sample, general observations suggest that medical pluralism is the norm in this country. People see no fault with mixing medical systems.

It seems scholars share one understanding about which contexts can be defined as medically pluralistic. Stock (1987:248), similar to Pearce, observes that "...in the Third World, the range of choice is usually very considerable, although the actual choice will vary according to culture and location. The first strategy available to the patient is to delay receiving treatment, giving the body a chance to heal itself. If treatment is to be obtained, the patient may choose between lay treatment (often self-administered) and professional therapy and between Western scientific, traditional and spiritual (faith healing) therapies". They also seem to agree that medical pluralistic contexts are prevalent in Africa. Once people are exposed to different sets of medical knowledge, they develop plurality in their understanding and conception of health and illness.

According to Han (2002), who stresses cultural explanations and factors, medical pluralism has been reproduced and sustained by three factors. It is important to note that his explanation, like that of others, assumes that the world is constructed around western medicine, and that anything which is not Western scientific medicine is alternative or complementary. Ironically he also assumes that the presence of other health systems alongside Western scientific medicine is what constitutes medical pluralism. He therefore believes that medical pluralism is made possible by the following factors:

- Patients may consult non-orthodox healers because they do not always agree with unfavourable comments made about them by orthodox medical doctors.
- Non-orthodox healers may be more easily accessible geographically and financially.
- People may be forced to take up any health service available in the hope that they may find relief.

He harmonizes this by arguing "the medical plurality is related to the freedom of choice that serves to place the patient in control of his environment, to give him options to strike what seems the best course for himself" (Han 2002:03). However, though medical pluralism emphasises the freedom of choice, we need to take into consideration other factors as well. Choice is based on knowledge; therefore, if the level of awareness is unequal, choice becomes bias. People choose what they best understand and tend to develop negative assumptions about other choices: they depend on what their society offers them.

The knowledge that people transmit within a society is firstly, socially constructed, and secondly, reproduced. This means that people might choose a traditional health system over a scientific health system because they have a better understanding of the former. Massive urbanization has resulted in the younger generation utilizing the scientific health system because they understand it better than any traditional one. It is more commercial, dominant and better marketed than its counterparts. Han (2002:05) writes, "Following critical realism, I argue that patient health-seeking behaviour is enabled and constrained by medical systems in the social context, but the action, in

turn, reproduces or transforms the medical systems". It is also important to note that it is not only knowledge that determines one's choices; there are factors like accessibility, affordability and others as well.

Han (2002:07) offers a definition of medical pluralism not dissimilar to that of other researchers: Medical pluralism could generally mean one or two things. The first meaning refers to the co-existence of various health care systems such as orthodox medicine, chiropractic, acupuncture, herbal medicine, osteopathy, bone setting and so on. Consumers have a right to choose from a pool of various types of therapies, each of which is unique in its own right. The second kind of meaning refers to pluralism within a particular system. For example, with orthodox medicine, a client has a choice to go to private or public hospital or to a doctor practicing in a village, or town or a distant city or overseas".

Similarly, Minocha (1980:217) states that the concept of medical pluralism can be understood in two ways, and like Han argues that "it may mean the co-existence of multiple systems of medicine including what are called folk systems, popular systems, traditional professionalized systems which presents multiple choices to individuals". Secondly, and most importantly, it may mean that "an individual has not only a choice between consulting an Ayurvedic practitioner or one practicing modern medicine but within modern medicine, he has a choice to go to a hospital (of a particular type) or to a doctor in private practice or a government dispensary, or a doctor practicing in a village, in a nearby or a distance city". The thesis of this research will focus primarily on the co-existence of multiple strategies in one social context.

Two aspects of Han's definition should be noted: firstly, his article is rooted in a Chinese context, and some health care systems mentioned in the quote might be alien to us. Secondly, however, there are similarities between the Chinese and African contexts. Han's definition is not incompatible with that of Pearce (1993:150), who argues that in a context of medical pluralism "lay people freely use and integrate aspects of competing knowledge bases in their attempt to handle health matters".

Pearce and Han both make use of critical ideological terms such as 'freedom', 'right' and 'freely'. These concepts assume that medical pluralism is not problematic, that it operates freely and smoothly, and that movement is unobstructed. This is not generally the case in Africa, as I hope to show; this study will focus on the co-existence of health care systems, though at times we might reflect on the pluralism within a particular health strategy.

In Africa some health care systems operate in a private domain or are responses to private or personal issues; Steven Freeman (1979:177) would call them 'closed intellectual systems of African traditional thought'. In these cases freedom is limited. Below, a critical examination of the prevailing health care systems will be done and an attempt made to unpack the concept of medical pluralism.

2.6 Critical Analysis of the concept

Pluralism has emerged as the dominant concept in the democratic dispensation, and has been strongly encouraged. Indeed, it has been argued that democracy without pluralism is doomed to fail. One could also argue the reverse: that pluralism without democracy cannot exist. We have made use of the concept of medical pluralism realizing its limitations. Cochrane et al (2003:02) argue that this concept is reductive and assumptive.

Firstly, it assumes that all responses to sickness are medical. Secondly, it assumes that health is about how we respond to sickness; therefore it downplays health promotion and illness prevention activities. In this research we propose that a greater regard be given to what people do to remain well and healthy, than what they do when they are not well. The thesis of this research is broad enough to cover all health related issues; therefore we have not limited ourselves to 'symptomatic relief seeking behaviour'. We have chosen, rather, to broaden our research to include 'health seeking behaviour'.

The concept of *medical pluralism* is based on the historic conception of health systems, and is therefore loaded with historical assumptions. It is difficult to escape the reality that our health systems are conceptualized around scientific medicine. Leslie's (1980:191) contention is that "the generic conception of medical systems is thus based on a single, historically recent system: a bureaucratically ordered set of schools, hospitals, clinics, professional associations, companies and regulatory agencies that train practitioners and maintain facilities to conduct biomedical research to prevent or cure illness and to care for or rehabilitate the chronically ill". In this approach the medical system neglects other forms of health care that are usually available in local communities, which are both intrinsically socially and culturally, embedded. Therefore there is a danger in assuming that health institutions are medical institutions. Paradoxically, we use the concept of health systems when we talk of different sources of health care, and we use the concept of medical pluralism when we refer to the diversity, whether conceptual or practical, of these health systems.

Press (1980:46) quotes Field who argues that "a society may, and often does have more that one medical system, and they may well overlap each other, but it may be argued that the totality of such systems constitutes the medical system of that society in contrast with other (non-medical) systems". We must make a distinction between a medical system and a health system; it is not clear whether different medical systems, when functioning together, constitute a medical system or whether different medical systems together constitute health systems.

We often talk of medical systems when we actually mean health systems. The concept of *medical pluralism* seems to be valid only if we call all health-seeking strategies 'medical'. Even then, we would still face problems because of what we highlighted earlier: that the concept medicine is itself limited and paradoxical. By implication the concept does not incorporate what happens to other health-seeking strategies because it is biased towards the western and is considered euro-centric. Therefore *medical pluralism* seems to refer to the secondary form of pluralism, i.e. pluralism within a particular system.

The concept of health system seems to be less problematic and more inclusive in that it does not reduce all other health care strategies to 'medical'. It appears to be incorporating non-medical activities, facilities and resources, which that function to restore and promote health. If one takes Press' (1980:46) definition seriously, that "a system is a functionally integrated entity with intercommunicating parts.", then we could reasonably argue that there has never been a single medical or health system, or at most, a health system should comprise a full range of conventional medical specialties plus para-medical disciplines and auxiliary services plus a variety of traditional, folk, alternative, complementary, and supplementary systems. It should be curative, restorative, preventive and promotional. It covers both physical and mental health and should deal with particular areas of application like public health, occupational hazards, sports medicine etc. A medical system in the traditional or conventional sense is only one component of this.

According to Press (1980:46) this is in contrast to the South Africa context where "there are sub-systems with diversely based paradigms and little or no two-way communication and influence among the parts". South Africa's situation falls short of that definition of 'system' in that, other modes of health care, which people utilize, are not constitutionally recognized, and are thus not legalized. It is therefore more appropriate to argue that in South Africa what we have are medical systems, because only institutionalized modes of health care are taken seriously.

The notion of *medical pluralism* is paradoxical and ambiguous because the concept of medicine is highly contested. The concept is problematic in the sense that it is usually only associated with an institutionalized health care service, and that there is a general assumption that medicine refers specifically only to Western medical practices. This should not come as a surprise, given the hegemonic, autonomous and prominent status that Western medicine enjoys. Seal and Pattison (1994:07) state that "medicine is commonly presented as a body of knowledge based on objective scientific principles. The practice of medicine is often seen straightforwardly as the application of that knowledge by doctors." They state further that during the twentieth century "modern medical knowledge based on scientific research is accepted as the dominant paradigm in explaining human health and diseases. It means an influential set of ideas about the

way the world is viewed which tends to discredit alternative views, at least for a time" (1994:28).

For Frazer and proponents of the evolutionary school of human intellectual development this could not be a surprise. Frazer contended long ago that humans evolve through certain stages. He argued that magic and religion give way to science, and to what he called human intellectual development. Pals (1996:45) explains that "Taylor and Frazer contend human beings have slowly improved themselves by creating ever more civilized communities, by learning more about both the extent and limits of their knowledge, and by treating each other with a gradually greater measure of decency, knowledge and compassion. To be sure, religion - an agent of progress insofar as it once took the mind of humanity a step beyond magic - has played its role in this great evolutionary drama, but only for a time. With the arrival of science that role is now ended". One wonders to what extent the emergence of alternatives such as religion-based activities constitute threats to his theory. In any event, the link between the emergence of alternative health care and various theories about science and religion remains unclear.

It is clear that the first sense of *medical pluralism* definition, namely, co-existence of various health strategies, is more appropriate for our purpose. This study is concerned with a multiplicity of health care systems; it is therefore about the plurality of health care strategies. Conventional western medical practice happens to be one such system and is in itself pluralistic. It is important to note that each health care system is in itself pluralistic. In the discussion that follows we will be dealing with the distinction between "intrinsic" and "extrinsic" pluralism. It should therefore be obvious that in studies of this nature it is crucial to be clear about how the concept of medical pluralism is used.

2.7 Plurality of medical knowledge

Until recently there has been little evidence of any effort on the part of the practitioners of biomedicine to understand 'other' medical knowledge, how it is used

and by whom. Farmer (2003:138) suggests that "physicians need social theory (including anthropology) in order to re-socialize their understanding of who becomes sick and why, and of who has access to health care and why". It is important to note that though research shows that health care systems are very conventional and distinctively demarcated in relation to one another, the *users* are less separatist, and hence have no problem with mixing various health seeking strategies.. Minocha's contention is that a closer view of what is happening reveals different levels of information, ranging from full knowledge about one or more systems to very superficial, if not distorted, notions about all or most medical systems. "People's knowledge about medicine and health therefore is actually a total of fragments of beliefs and practices found in diverse systems" (1980:218).

What happens in practice "on the ground" is more extensive and more complex than what is stated in any of the current definitions of medical pluralism. Minocha (1980:217) states that "one may notice pluralism in people's conceptions of disease and illness; they resort to medical practices belonging to different systems, and in their responses to other medical dimensions". Farmer (2003:138) pursues the idea and adds: "... medicine becomes pragmatic solidarity only when it is delivered with dignity to the destitute sick" when trying to understand what people do when they are sick. Clearly then, there are quite a number of issues that need to be taken into consideration, that can influence and determine the ultimate choice of where people seek help.

According to Minocha (1980:218), "It is often assumed that, when making a choice, people are fully aware of the underlying ideologies of the systems, i.e. that they make a conscious choice based on substantial knowledge about the distinguishing and distinctive characteristics of various systems". Though medical and health knowledge may be very important when such choices need to be made, knowledge is not always a deciding factor. There are many factors other than knowledge that influence health choices. Though it is not necessary to dwell here on those issues, it should be noted in passing that among them are the distribution of health facilities and resources, geographical issues in terms of distance, urban/rural differences, economic and social living conditions.

In many instances health care alternatives are limited; therefore freedom of choice is also limited, and an individual might receive pluralistic therapeutic explanations about one particular illness. Earlier we touched upon two types of medical pluralism; one could argue that even though scholars state that medical pluralism is a world-wide phenomenon, there are nonetheless differences between western and third world conceptions of pluralism and usage of the term. In the former, medical pluralism tends to refer to pluralism within one system; in the latter it is understood to mean a choice among various types of therapies. Freeman (1979:280) quotes Jansen who describes six cases in detail, each of which progresses through a complex course of therapy, from hospital to magician, from magician to clan reunion and finally to healing cult.

2.8 Communal essence of medicine

In Africa, knowledge of therapy is acquired through experience and transmitted from generation to generation. In this sort of context, the more usual expression would be: a sick person is often caught in a web of sometimes conflicting, causal explanations, each having its own therapeutic implications. These tend to confuse, or even negate any opportunity to exercise freedom of choice. Freeman (1979:28) explains that "in a pluralistic system, choice is in the hands of a therapy management group - those people who know the patient best, even though they normally have no specialized knowledge of disease or therapy". In some instances communal decisions are made, and in others the patient is caught between complex explanations of therapies. The management group itself has the potential to advance the ideology of medical pluralism; they may hold different views on therapeutic choice, or they may be more homogeneous and show inclinations towards communal cooperation.

2.9 Displacement and cultural disorientation

Most South African black people in urban settings are historically displaced, largely through statutory racial segregation ('apartheid') and internal patterns of migratory labour, rigidly enforced until the late 1980's. Such physical-geographic displacement

has profound social implications and consequences - one of them being a radical change in therapy management group. As a result also, people may be exposed to different threats to health and/or face difficulties in managing different illnesses from those they were familiar with, or for which they had systems of understanding and treatment. Freeman (1979:282) states that "the much greater spatial dispersal of close relatives in the twentieth century, with some living in large cities and some moving across the countryside, combined with increase in occupational differentiation, and in degree of alienation of social production, mean that many of the most basic conditions of life, which affect the health and well-being of each individual, are beyond the control of those assisting in social welfare." People in the cities are faced for the first time with several competing or complementary worldviews, and often become confused. Many, however, maintain close contact with their traditional rural roots and find themselves in the predicament of living between two worldviews.

2.10 Reasons for health care preference

Geographers who have been involved in the study of medical practices in Africa tend to assume that the prevalence of alternative medicine is directly related to the distance from western-type health-care facilities. They tend to believe that residents of the most remote rural areas are the ones who utilize alternative medicine most frequently. Referring to his own research findings, Stock (1987:284) states: "It is evident that alternatives to institutional health care serve the vast majority of health care needs of the study population, and that the relative importance of these alternatives increases rapidly as the distance from western-type health care facility rises."

Minocha is somewhat more tentative: "The real bases are the availability, accessibility and quality of medical care provided by the diverse systems, and people's past experiences in particular disease episodes. Quite often the choice is also influenced by the relative position held by the sick person vis-à-vis the decision maker." Both Stock and Minocha seem to challenge assumptions that people prefer traditional medicine because they feel at home with it and thus reject modern medicine as alien to them.

It is our hope that this study will bring another dimension to the knowledge base of health seeking behavior in a peri-urban medical pluralistic context. We are studying urban township dwellers with much better access to health resources than rural dwellers. It seems to me that though distance might be a factor when it comes to making a choice of therapeutic strategy, it is not the only factor. Comparing rural and urban access to proper health care is a project on its own, and is beyond the scope of this study. For the purposes of this study we assume that township inhabitants (semi-urban) utilize alternative medicine alongside western medicine, in spite of easier access to western systems than their rural counterparts.

2.11 Conclusion

We have explored the historical and contemporary uses of terms pertinent to the concept of health. We have looked at how historical embeddedness of the concept can affect our contemporary understanding. We have clarified that "pluralism" extends from the reality of the physical and social everyday life context to conceptual constructs based on available information regarding illness and its causation. In the process of health-seeking strategy choice, these concepts carry far more weight than issues of simple spatial context. We have recognized that "pluralism" can be extended from contextual to conceptual constructs based on available information; it doesn't matter much what the context presents - what matters most is the knowledge. Once the context becomes pluralistic then the knowledge also becomes pluralistic.

We have discovered that mixing therapeutic strategies is a common practice all over the world, especially in third world countries like China, Korea, India and African nations. Reasons include issues of accessibility, affordability, socio-cultural beliefs and practices etc., though we have not elaborated upon them here. Medical pluralism has been explored and we contend that it means complementary, supplementary, alternative and contradictory use of health systems.

This chapter has raised research questions to which the research described below is a response. It is not clear why and under what circumstances people are mixing health-

healing systems; there are assumptions prevalent that do not seem to be sound. We have differentiated between pluralism within a health system and pluralism among health systems. We have argued that each health system, whether scientific or traditional, is in itself pluralistic. We have taken the concept of medical pluralism and attempted to dissect it by indicating assumptions and raising questions. We have also discussed factors that sustain medical pluralism, and argued that it is a social reality that cannot be ignored. Therefore it is important to find ways of coping with this pluralism rather than ignoring it.

We have also proposed that it can be productive to replace the concept of medicine with that of "health pluralism" due to the historical understanding and ambiguity of the term medicine.

CHAPTER 3

Findings

3.1 Introduction

Chapter 3 of this study report describes the findings of the research work done in the field using the survey and interviews.

There are two major variables that have been identified in this study, Christian grouping and gender variables. A number of potential variables were tested before reaching this conclusion, and no other significant patterns were found. Some of the variables tested were: age, languages spoken, economic status/condition, employment status, and whether interviewees regard the Cape Town metropole as their home. In fact, almost all our respondents have strong rural links. Almost all of our respondents could speak English and the majority of them could also speak Afrikaans. Their choice of strategy was not influenced by languages they speak. In all the variables tested, except church grouping and gender variables, we identified no relationships between a variable and the choice of health seeking strategy; no other variables influenced the respondent's choice of health seeking strategies.

In this chapter we report the health seeking strategies of our respondents grouped by Christian affiliation. Major patterns emerge. This will be followed by a report of findings on the gender variable. The gender variable is also used to categorize questions about health seeking behaviour. The aim is to examine the patterns of behaviour of male and female respondents.

Three types of Christian groupings have been identified for this study: Ecumenical/Mission grouping, AIC-Zionist and AIC-non-Zionist. As stated earlier we endeavoured to establish whether the denominational background of the target group influences the respondent's health-seeking behaviour.

Ideally we would have liked to include in the sample an equal number of respondents from each of the dominant Christian grouping, but for various practical reasons (noted

earlier) this was not possible. Nevertheless the patterns of behaviour of each of the Christian grouping categories can be identified from their responses to the questions about health-seeking behaviour.

The variable "Christian grouping Classification" will be used to categorize the questions about healing-seeking behaviour.

As we anticipated, almost all our respondents were mixing health-seeking strategies either way: different ailments different strategies or multiple strategies single ailment. Only 3 out of 35 respondents clearly and consistently use faith health healing for all types of illnesses.

Table 3.1: Frequency Distribution of Variable Q15: Christian grouping Classification

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
AIC-Zionist	9	9	26	26
Ecumenical/Mission	18	27	51	77
AIC-Non Zionist	8	35	24	100
Missing	0	35		

[2]

Textual Summary

While individual figures show that the Ecumenical/Mission group to be the largest (51%), the AIC grouping (AIC-Zionist and AIC-non Zionist) taken together, is about equal (49%). This provides for an interesting comparison between AICs and what one might call "European or North American founded churches", which is one way of describing the origins of the Ecumenical/Mission group. At the same time, caution must be exercised when it comes to specific churches, as some AICs have strong roots in the northern hemisphere as well. The difference lies mostly in who took the lead in establishing or "instituting" the denomination or particular church.

[2] Percentages in all the tables are rounded off to whole numbers, and in some case this may produce a combine set of percentages that do not add up exactly to 100%.

3.2 Christian grouping's response about themselves

Table 3.2: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q16: Strategies for Serious Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	11	11
Western & Traditional	5	7	28	39
Western medicine	10	17	55	94
Traditional healing	1	18	6	100
Missing	0	18	0	

Textual summary

- Fifty six percent (10/18) of the respondents who are members of the Ecumenical/Mission grouping said that when they experience ***Serious Physiological Illness*** they use Western Medicine. A further 28% (5/18) use Western Medicine together with Traditional Healing.
- Eleven percent (2/18) said that they use Faith Healing and only 6% (1/18) of the respondents said they exclusively use Traditional Healing.
- The vast majority (84%) of respondents from the Ecumenical/Mission grouping said they use Western Medicine either on its own or together with Traditional Healing.
- A little over a quarter (5/18) of the respondents from the Ecumenical/Mission grouping said that they mix Western Medicine and Traditional Healing. Four of the five said that they mix Western Medicine and Traditional Healing because the first choice strategy did not work; in this regard, three used Western Medicine as their first choice strategy.

Table 3.3: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q16: Strategies for Serious Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Western & Traditional	1	3	11	33
Western medicine	3	6	33	67
Western, Traditional & Faith	3	9	33	100
Missing	0	9	0	

Textual summary

- Thirty three percent (3/9) of the respondents who are members of the AIC-Zionists grouping said that when they experience ***Serious Physiological Illness*** they use Western Medicine. A further 33% (3/9) use Western Medicine together with Traditional Healing and Faith Healing.
- Twenty two percent (2/9) said that they exclusively use Faith Healing.
- The vast majority (77%) of respondents from the AIC-Zionist grouping said that they use Western Medicine either on its own or with other health-seeking strategies. Those who mix health-seeking strategies prefer to combine all the three health-seeking strategies identified in this study.

Table 3.4: Frequency Distribution of the respondents by members of the AIC (non-Zionist) grouping to Variable Q16: Strategies for Serious Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	4	4	50	50
Western medicine	2	6	25	75
Western & Faith	1	7	12.5	88
Western, Traditional & Faith	1	8	12.5	100
Missing	0	8	0	

Textual Summary

- Twenty five percent (2/8) of respondents from the AIC non-Zionist grouping said that when they experience ***Serious Physiological Illness*** they used Western Medicine. A further 12,5% (1/8) used Western Medicine together with Faith Healing and 12,5% (1/8) used Western Medicine together with Traditional Healing and Faith Healing.
- Fifty percent (4/8) of the respondents said they use exclusively Faith Healing.
- Half the AIC non-Zionist grouping said that they used Western Medicine either on its own or together with one or more of the health-seeking strategies. The other half exclusively used Faith Healing.

3.2.1 Comparative Discussion of tables 3-4

When we compare the three Christian groupings' responses to ***Serious Physiological Illness*** we notice the following:

i. Those in the Ecumenical grouping are more inclined than those in the other two groupings to use Western Medicine. If they mix approaches, then they only combine Western Medicine and Traditional Healing. There is very little use of Faith Healing.

ii. Those in the AIC Zionist grouping are inclined to use Western Medicine less than the Ecumenical grouping but more often than the Non-Zionist grouping. They tend to combine all three health-seeking strategies. They are more inclined to use Faith Healing exclusively than those in the Ecumenical Grouping.

iii. Those in the AIC Non-Zionist grouping are least inclined to use Western Medicine and more inclined than the other two groupings to exclusively use Faith Healing. They also mix approaches, but not to the extent that the AIC Zionists do.

The majority of respondents in this category of Christian grouping said they treat healing strategies equally when they are mixing approaches. Those who have strong confidence or "faith" in Faith Healing and Traditional Healing said they only mix these with Western Medicine when they are seriously ill and weak, in order to be strong enough to withstand the Faith Healing and Traditional Healing enemas. This means that, unlike those who mix approaches because one strategy does not work, they mix because they feel that one strategy has its own specific role in their well being, i.e. Western Medicine provides medication that will make them strong, to better prepare for Faith Healing or Traditional Healing which will cure the ailment.

Table 3.5: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q17: Strategies for Mild Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Western & Traditional	4	4	22	22
Western medicine	13	17	72	94
N/A	1	18	6	100
Missing	0	18	0	

Textual summary

- Seventy two percent (13/18) of the respondents from the Ecumenical/Mission Christian grouping said that when they experience ***Mild physiological Illness*** they

use Western Medicine. A further 22% (4/18) use Western Medicine together with Traditional Healing. None of the respondents said they use Faith Healing on its own or together with other health seeking strategies.

- All the respondents the Ecumenical/Mission grouping said they use Western Medicine on its own or together with Traditional Healing.
- The respondents in the Ecumenical/Mission Christian grouping tend to use Western Medicine preferentially. They said that they first use Western Medicine and only when it does not appear to work do they adopt a different health-seeking strategy, that is, Traditional Healing.

Table 3.6: Frequency Distribution of the respondents by members of the AIC Zionist grouping to Variable Q17: Strategies for Mild Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Western medicine	3	5	33	56
Traditional healing	1	6	11	67
Western, Traditional & Faith	3	9	33	100
Missing	0	9	0	

Textual summary

- Thirty three percent (3/9) of the respondents from the AIC Zionist grouping said that when they experience ***Mild Physiological Illness*** they use Western Medicine. A further 33% (3/9) use Western Medicine together with Traditional Healing and Faith Healing. Two thirds (66%) of the members of the AIC Zionist grouping used Western Medicine either on its own or together with other health-seeking strategies. Those who mix health-seeking strategies when they experience ***Mild Physiological Illness*** prefer to combine all the three health-seeking strategies identified in this study.
- Twenty two percent (2/9) used Faith Healing while only 11% (1/9) used Traditional Healing. Faith Healing is more prevalent in this Christian grouping than is the case with the respondents from the Ecumenical/Mission grouping.

Table 3.7: Frequency Distribution of the respondents by members of the AIC Non-Zionist grouping to Variable Q17: Strategies for Mild Physiological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	3	3	38	38
Western medicine	3	6	38	75
Western, Traditional & Faith	1	7	12	88
Western & Faith	1	8	12	100
Missing	0	8	0	

Textual summary

- Thirty eight percent (3/8) of the respondents who are members of the AIC Non-Zionist grouping said that when they experience ***Mild Physiological Illness*** they use Western Medicine. A further 12% (1/8) use Western Medicine together with Faith Healing and another 12% (1/8) combine Western Medicine, Faith Healing and Traditional Healing. A majority (62%) of respondents from the AIC Non-Zionist grouping use Western Medicine either on its own or together with other health seeking strategies.
- Western Medicine and Faith Healing are the two dominant health-seeking strategies. Both strategies are also used by those who mix health-seeking strategies.
- Thirty eight percent (3/8) said that they use Faith Healing. None of the respondents use Traditional Healing on its own.

Faith Healing, on its own or in combination with other health-seeking strategies, is far more predominant among respondents from the AIC Non-Zionist grouping than in any of the other groupings. Their responses to other questions show that they tend to use Western Medicine when they are physically weak and it would be risky for them to use Faith Healing enemas. In other words, they use Western Medicine for medication that will make them strong, to better prepare for Faith Healing or Traditional Healing to cure the ailment. They believe that Western Medicine gives them strength to stand Faith and Traditional healing enemas which they believe will cure the ailment.

3.2.2 Comparative Discussion for tables 5-7

When we compare the three denominational groupings' responses to ***Mild Physiological Illness*** we notice the following:

i. Those in the Ecumenical grouping are more inclined than those in the other two groupings to use Western Medicine. If they mix they only combine Western Medicine and Traditional Healing. They do not make use of Faith Healing.

ii. Those in the AIC Zionist grouping are inclined to use Western Medicine less than the Ecumenical grouping but more often than the Non-Zionist grouping. When they mix they tend to combine all three health-seeking strategies. They are more inclined to exclusively use Faith Healing than those in the Ecumenical Grouping.

iii. Those in the AIC Non-Zionist grouping are, like those from the AIC Zionist grouping, inclined to use Western Medicine less than the Ecumenical grouping. They more inclined than the other two groupings to exclusively use Faith Healing. Some mix, but not to the extent that the AIC Zionists do. They tend to use less Traditional Healing than those in the other two groups.

Table 3.8: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q18: Strategies for Psychic Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	3	3	17	17
Traditional healing	9	12	50	67
Western & Traditional	1	13	5.5	72
Traditional & Faith	4	17	22	94
N/A	1	18	5.5	100
Missing	0	18	0	

Textual summary

- Fifty percent (9/18) of the respondents from the Ecumenical/Mission grouping said that when they experience ***Psychic Illness*** they exclusively use Traditional Healing. A further 22% (4/18) use Traditional Healing together with Faith

Healing. Only 5% (1/18) combine all three strategies. A large majority of respondents (72%) said that, when they experienced Psychic illness, they used Traditional Healing on its own or together with Faith Healing.

- Seventeen percent (3/18) of the respondents exclusively used Faith Healing.
- None of the respondents said they used Western Medicine on its own in this case.
- Traditional Healing and Faith Healing are the two dominant health-seeking strategies. Both strategies are also used by almost all of those who mix health-seeking strategies.

Table 3.9: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q18: Strategies for Psychic Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Traditional healing	3	5	33	56
Western, Traditional & Faith	2	7	22	78
Traditional & Faith	1	8	11	89
N/A	1	9	11	100
Missing	0	9	0	

Textual summary

- Thirty three percent (3/9) of respondents from the AIC-Zionist said when they experience ***Psychic Illness*** they use Traditional Healing. A further 22% (2/9) said they use Traditional Healing, Faith Healing and Western Medicine. Another 11% (1/9) use Traditional Healing and Faith Healing. The large majority (66%) of respondents said they use Traditional Healing either on its own or together with other health seeking strategies. Mixing mainly involves all the three health-seeking strategies.
- Twenty two percent (2/9) of the respondents said they used Faith Healing. None of the respondents said they used Western Medicine alone. Faith Healing is a second preference for AIC-Zionist when they experience Psychic illness.

Table 3.10: Frequency Distribution of the respondents by members of the AIC-non Zionist grouping to Variable Q18: Strategies for Psychic Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	3	3	37.5	38
Traditional & Faith	2	5	25	62
N/A	3	8	37.5	100
Missing	0	8	0	

Textual summary

- Thirty eight percent (3/8) of respondents from the AIC-non Zionists said when they experience ***Psychic Illness*** they used Faith Healing. A further 25% (2/8) said they use Faith Healing together with Traditional Healing. The small majority (63%) of respondents from the AIC-non Zionists said when they experience ***Psychic Illness*** they use Faith Healing. Mixing is mainly of Faith Healing and Traditional Healing.

3.2.3 Comparative Discussion of tables 8-10

When we compare the three Christian groupings' responses to ***Psychic Illness*** we notice the following:

i. Those in the Ecumenical grouping are more inclined than those in the other two groupings to use Traditional Healing. If they mix they only combine Traditional Healing and Faith Healing. There is very little use of Western Medicine and if used, it becomes part of a mixed strategy.

ii. Those in the AIC Zionist grouping are inclined to use Traditional Healing less than the Ecumenical grouping but more often than the Non-Zionist grouping. They tend to combine all three health-seeking strategies. They are more inclined to use Western Medicine as mixed strategy than the other two groupings.

iii. Those in the AIC Non-Zionist grouping are least inclined to use Traditional Healing and more inclined than the other two groupings to exclusively use Faith Healing. They also mix but not to the extent that the AIC Zionists do. There is no use of Western Medicine in this grouping.

Table 3.11: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q19: Strategies for Psychological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	11	11
Western medicine	10	12	55	67
Traditional healing	1	13	5	72
Western & Traditional	5	18	27	100
Missing	0	18	0	

Textual summary

- Fifty five percent (10/18) of the respondents from Ecumenical/Mission grouping said that when they experience ***Psychological illness*** they use Western Medicine. A further 28% (5/18) use Western Medicine and Traditional Healing.
- The vast majority (84%) of respondents from the Ecumenical/Mission grouping said they use Western Medicine either on its own or together with Traditional Healing.
- Eleven percent (2/18) of the respondents said that they use Faith Healing. Only 6% (1/18) said they use Traditional Healing alone.
- Even when mixing they said they would mix Western Medicine and Traditional Healing. We have discovered that members of this Christian grouping use Traditional Healing when Western Medicine does not work; this was demonstrated by their responses to questions about why and how they mix health-seeking strategies. They also said that they go first to the doctor, and then to the other, 'alternative' medicine provider.

Table 3.12: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q19: Strategies for Psychological illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Western medicine	2	4	22	44
Traditional healing	2	6	22	67
Western & Traditional	1	7	11	78
Western, Traditional & Faith	2	9	22	100
Missing	0	9	0	

Textual summary

- Twenty two percent (2/9) of the respondents who are members of the AIC-Zionist grouping said that when they experience ***Psychological illness*** they use Western

Medicine. A further 22% (2/9) said that they use Western Medicine, Traditional Healing and Faith Healing; a further 11% (1/9) said they used Western Medicine and Traditional Healing.

- Twenty two percent (2/9) of the respondents use Faith Healing, and an equal number use Traditional Healing.
- Just over half (55%) of the respondents from the AIC-Zionist grouping said that they use Western Medicine either on its own or together with other health seeking strategies.
- An equal number of respondents (55%) said they use Traditional Healing.
- The distribution of responses by respondents from AIC-Zionist grouping is balanced. It is difficult therefore to project their actual behaviour.

Table 3.13: Frequency Distribution of the respondents by members of the AIC-non Zionists grouping to Variable Q19: Strategies for Psychological Illness

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	6	6	75	75
Western medicine	1	7	12.5	87
Western & Traditional	1	8	12.5	100
Missing	0	8	0	

Textual summary

- Seventy five percent (6/8) of the respondents from the AIC-non Zionist grouping said that when they experience Psychological illness they use Faith Healing.
- Twelve percent (1/8) of the respondents said that they use Western Medicine. A further 12% (1/8) they use Western Medicine and Traditional Healing.
- The vast majority (75%) of respondents who are members of the AIC-non Zionist grouping said they use Faith Healing exclusively.
- Twenty five percent (2/8) of these respondents said they used Western Medicine either alone or together with Traditional healing. This is a little surprising because of the common use of faith healing in African Independent Churches as a response to psychological illness.

3.2.4 Comparative Discussion of table 10-13

When we compare the three denominational groupings' responses to Psychological Illness we notice the following:

i. Those in the Ecumenical/Mission grouping are more inclined than those in the other two groupings to use Western Medicine. If they mix they only combine Western Medicine and Traditional Healing. There is very little use of Faith Healing.

ii. Those in the AIC Zionist grouping are inclined to use Western Medicine less than the Ecumenical grouping but more often than the Non-Zionist grouping. They also tend to combine all three health-seeking strategies. They are more inclined to use Faith Healing than those in the Ecumenical Grouping.

iii. Those in the AIC Non-Zionist grouping are least inclined to use Western Medicine and more inclined than the other two groupings to exclusively use Faith Healing. They rarely use Traditional Healing.

3.2.5 Comparative Discussion of the three Christian groupings` response to all illnesses (tables 2-13)

When we compare the three denominational groupings' responses to all ***Illnesses*** we notice the following:

i. Ecumenical/Mission respondents have a much stronger tendency to Western Medicine than the other two groupings in almost all illnesses with the exception of Psychic illness. We noted that Ecumenical/Mission respondents deflected from preferring Western Medicine as a dominant strategy for other illness to preferring Traditional Healing when they experience Psychic Illness. In other words we noted very little use of Western Medicine when they experience Psychic Illness. When they mix approaches, they combine Western Medicine and Traditional Healing in all the illness categories except Psychic Illness, where they prefer to combine Traditional Healing and Faith

Healing. They are less inclined to use Faith Healing than the other two groupings; for example they said they would not consider Faith Healing at all when they experience Mild Physiological illness (see Variable Q17).

ii. Those in the AIC-Zionist grouping are inclined to use Western Medicine less than the Ecumenical/Mission grouping, but more than the AIC-non Zionist. They are more inclined to Faith Healing than those in the Ecumenical/Mission grouping, but less than those in the AIC-non Zionist. They have a greater tendency to combine all the three health-seeking strategies than the other two groupings. However, similar to Ecumenical/Mission, they are more inclined to Western Medicine, with the exception of Psychic illness where they are more inclined to turn to Traditional Healing.

iii. AIC non-Zionist respondents have a much stronger tendency toward Faith Healing exclusively and are less inclined to Western Medicine than the other two groupings. They are the only group that said they would not use Western Medicine at all when they experience Psychic illness.

iv. In all the illnesses we identified we noticed that respondents from all the three denominational groupings mix approaches to healing.

v. We noticed that Ecumenical/Mission respondents and AIC-Zionist respondents deflected from preferring Western Medicine as a predominant strategy when they experience Mild and Serious Physiological and Psychological illness, to preferring Traditional Healing when they experience Psychic illness. Ecumenical/Mission respondents also deflected from preferring Traditional Healing as a second preference to Faith Healing, though they have less 'faith' to it when it comes to other types of illnesses.

3.3 Christian grouping's responses about members of their families

The previous data concerned the response of the interviewee to her or his own illness. We now shift to data concerning the illnesses of those near to them or members of their families, as an additional variable, to determine whether their choices and preferences remain constant or change for others. These questions provide an index of how strongly our respondents feel about the strategies they were using. The rationale for asking questions about family has been documented in the methodology section of this paper. There is no comparative discussion of the three Christian groupings in response to different types of illnesses as done above because that would only be determined by what respondents actually does in response to sickness of members of their families. Therefore under each table we make a comparison of what the respondents do for themselves when they experience different types of illness and what they would encourage family members to do. We have noticed that apart from a few exceptions that are discussed in the analytical summary, most of our respondents from different Christian groupings said that they would do the same thing for members of their families as they would do for themselves when they experience the different types of illnesses we identified.

Table 3.14: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q20: Strategies for Serious Physiological Illness for a member of the family

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	1	1	6	5
Traditional healing	2	3	11	17
Western medicine	11	14	61	78
Western & Faith	1	15	6	83
Western & Traditional	3	18	17	100
Missing	0	18	0	

Textual summary

- Sixty-one percent (11/18) of the respondents from the Ecumenical/Mission grouping said they would encourage members of their family experiencing Serious Physiological Illness to use Western Medicine. A further 17% (3/18) would encourage them to use Western Medicine together with Traditional Healing. Only 6% (1/18) would encourage them to use Western Medicine and

Faith Healing. The vast majority (84%) of respondents said they would encourage family members to use Western Medicine, either on its own or together with other health seeking strategies.

- Comparatively, what the respondents do when they experience Serious Physiological Illness is similar to what they would encourage members of their families to do. They are marginally more inclined to encourage family members to use Western Medicine than they would for themselves.

Table 3.15: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q20: Strategies for Serious Physiological Illness for a member of the family

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	1	1	11	11
Western & Faith	1	2	11	22
Western & Traditional	6	8	67	89
Western, Traditional & Faith	1	9	11	100
Missing	0	9	0	

Textual summary

- Sixty seven percent (6/9) of the respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing Serious Physiological illness to use Western Medicine and Traditional Healing. A further 11% (1/9) said they would encourage members of their family to use Western Medicine, Traditional Healing and Faith Healing.
- Responses from this Christian grouping are characterized by considerable mixing, and ideally all the respondents would encourage members of their family to use Western Medicine together with either Traditional Healing or Faith Healing, or to use all the three, with an emphasis on using Western Medicine together with Traditional Healing.
- Comparatively, what the respondents do when they experience ***Serious Physiological Illness*** is different to what they would encourage members of their families to do. While they are more inclined to use Western Medicine, and when they mix, tend to combine all the three health-seeking strategies, they would encourage members of their family to use Western Medicine and Traditional Healing. They therefore would encourage them to use less Faith Healing than they would do themselves. The reason is not know, but intriguing.

Table 3.16: Frequency Distribution of the respondents by members of the AIC-non Zionist grouping to Variable Q20: Strategies for Serious Physiological Illness for a member of the family

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	4	4	50	50
Western medicine	1	5	12.5	62
Western & Faith	2	7	25	88
Western & Traditional	1	8	12.5	100
Missing	0	8	0	

Textual summary

- Fifty percent (4/8) of the respondents who are members of the AIC-non Zionist said they would encourage members of their family experiencing Serious Physiological illness to use Faith Healing. A further 25% (2/8) would encourage members of their family experiencing Serious Physiological illness to use Faith Healing together with Western Medicine.
- The vast majority (88%) of the respondents who are members of the AIC-non Zionist said they would encourage members of their family experiencing Serious Physiological illness to use Faith Healing.
- We noticed no differences relative to how they responded to the same question when it was asked in relation to themselves. They would encourage family members to do exactly the same thing as they do for themselves.

Table 3.17: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q21: Strategies for Mild Physiological Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Western medicine	13	13	72	72
Western & Traditional	5	18	28	100
Missing	0	18	0	

Textual summary

- Seventy two percent (13/18) of the respondents who are members of the Ecumenical/Mission grouping said they would encourage members of their family experiencing ***Mild Physiological Illness*** to use Western Medicine. A further 28% (5/18) said they would use Western Medicine together with Traditional Healing.
- The vast majority, almost all the respondents who are members of the Ecumenical/Mission grouping, said they would encourage members of their family experiencing Mild illness to use Western Medicine.

- Comparatively, what the respondents do when they experience ***Mild Physiological Illness*** is similar to what they would encourage members of their families to do.

Table 3.18: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q21: Strategies for Mild Psychological Illness for a member of the family

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Western medicine	3	5	33	56
Western & Traditional	2	7	22	78
Traditional healing	1	8	11	89
Western, Traditional & Faith	1	9	11	100
Missing	0	9	0	

Textual summary

- Thirty three percent (3/9) of the respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing ***Mild Physiological illness*** to use Western Medicine. A further 22% (2/9) said they would encourage members of their family experiencing Mild Physiological to use Western Medicine together with Traditional Healing. Just over half of the respondents from the AIC-Zionist grouping said they would encourage members of their family to experiencing mild illness to use Western Medicine either alone or together with Traditional Healing.
- Twenty two percent (2/9) of respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing Mild Physiological illness to use Faith Healing.
- When we compare how they responded to this question when it was asked personally, we find no major differences, though they would encourage family members to mix Western Medicine and Traditional, while they prefer mixing all the three heath seeking strategies for themselves.

Table 3.19: Frequency Distribution of the respondents by members of the AIC-non Zionist grouping to Variable Q21: Strategies for Mild Psychological Illness for a member of the family

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	25	25
Western medicine	4	6	50	75
Western & Faith	2	8	25	100
Missing	0	8	0	

Textual summary

- Fifty percent (4/8) of the respondents who are members of the AIC-non Zionist grouping said they would encourage members of their family experiencing ***Mild Physiological Illness*** to use Western Medicine. A further 25% (2/8) said they would encourage them to use Western Medicine and Faith Healing. The vast majority (75%) of respondents who are members of the AIC-non Zionist grouping said they would encourage members of their family to use Western Medicine.
- Twenty five percent (2/8) of the respondents said they would encourage them to use Faith Healing. Half (50%) of the respondents said they would encourage members of their family experiencing Mild illness to use Faith Healing.
- Comparatively, what the respondents do when they experience ***Mild Physiological Illness*** is different to what they would encourage members of their families to do. While they are inclined to use Faith Healing, they are marginally more inclined to encourage family members to use Western Medicine on its own, or with Faith Healing, than they do for themselves.

Table 3.20: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q22: Strategies for Psychic Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	4	4	22	22
Traditional healing	8	12	44	67
Traditional & Faith	4	16	22	89
Western & Traditional	1	17	6	94
Western medicine	1	18	6	100
Missing	0	18	0	

Textual summary

- Forty four percent (8/18) of the respondents who are members of the Ecumenical/Mission grouping said they would encourage members of their family experiencing ***Psychic Illness*** to use Traditional Healing. A further 22% (4/18) encouraged use of Traditional Healing and Faith Healing. A large majority (72%) of respondents who are members of the Ecumenical/Mission grouping said they would encourage members of their family to use Traditional Healing either on its own or together with Faith Healing when they experience ***Psychic Illness.***
- Twenty two percent (4/18) said they would encourage them to use Faith Healing.

- There are no substantial differences between what they would do for themselves and what they would encourage family members to do. As with their responses about themselves we noticed a clear shift away from Western Medicine to Traditional Healing and Faith Healing.

Table 3.21: Frequency Distribution of respondents by members of the AIC-Zionist grouping to Variable Q22: Strategies for Psychic Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Traditional healing	4	6	45	67
Western & Traditional	2	8	22	89
Western, Traditional & Faith	1	9	11	100
Missing	0	9	0	

Textual summary

- Forty four percent **(4/9)** of the respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing ***Psychic Illness*** to use Traditional Healing. A further 22% (2/9) said they would encourage them to use Traditional Healing and Western Medicine. A large majority (66%) of respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing ***Psychic Illness*** to use Traditional Healing either on its own or together with Western Medicine..
- Twenty two percent (2/9) of the respondents who are members of the AIC-Zionist grouping said they would use Faith Healing.
- Comparatively, what the respondents do when they experience *Psychic Illness* is similar to what they would encourage members of their families to do. They are marginally more inclined to encourage family members to use Traditional Healing than they would do for themselves.

Table 3.22: Frequency Distribution of the respondents by members of the AIC-non Zionist grouping to Variable Q22: Strategies for Psychic Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	6	6	75	75
Traditional & Faith	2	8	25	100
Missing	0	8	0	

Textual summary

- Seventy five percent (6/8) of the respondents who are members of the AIC-non Zionist grouping said they would encourage members of their family experiencing ***Psychic Illness*** to use Faith Healing. A further 25% (2/8) said they would encourage members of their family experiencing Psychic illness to use Faith Healing and Traditional. All (100%) the respondents who are members of AIC-non-Zionist grouping said they would encourage members of their family experiencing ***Psychic Illness*** to use Faith Healing on its own or together with Traditional Healing. It is important to note that the vast majority of all the respondents said they would encourage members of their family to use Faith Healing on its own.
- With reference to what they would practice for themselves we note that they would encourage family members to do the same. The only difference is that 38% (3/8) of these respondents said they had never been in this situation; alternatively they would encourage members of their family to use Faith Healing.
- The tendency of this relationship of AIC-Non Zionist to Faith Healing is still predominant even when they engage in advising members of their families.

Table 3.23: Frequency Distribution of the respondents by members of the Ecumenical/Mission grouping to Variable Q23: Strategies for Psychological Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	11	11
Traditional healing	1	3	5.5	17
Western medicine	7	10	39	56
Western & Faith	2	12	11	67
Western & Traditional	5	17	28	94
N/A	1	18	5.5	100
Missing	0	18	0	

Textual summary

- Thirty eight percent (7/18) of the respondents who are members of the Ecumenical/Mission grouping said they would encourage members of their family experiencing ***Psychological Illness*** to use Western Medicine. A further 27% (5/18) said they would encourage them to use Western Medicine and Traditional Healing and a further 11% (2/18) said they would encourage them to use Western Medicine and Faith Healing. A vast majority (76%) of the respondents who are

members of the Ecumenical/Mission grouping said they would encourage members of their family experiencing Psychological illness to use Western Medicine together with Traditional Healing.

- Eleven percent (2/18) of the respondents who are members of the Ecumenical/Mission grouping said they would encourage them to use Faith Healing
- Comparatively, there are no major differences between what respondents from the ecumenical grouping would do for themselves and what they would encourage members of their family to do.

Table 3.24: Frequency Distribution of the respondents by members of the AIC-Zionist grouping to Variable Q23: Strategies for Psychological Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	22	22
Traditional healing	1	3	11	33
Western medicine	3	6	33	67
Western & Faith	1	7	11	78
Western & Traditional	2	9	22	100
Missing	0	9	0	

Textual summary

- Thirty three percent (3/9) of the respondents who are members of the AIC-Zionist grouping said they would encourage members of their family experiencing ***Psychological Illness*** to use Western Medicine. A further 22% (2/9) said they would encourage them to use Western Medicine and Traditional Healing. A majority of respondents said they would encourage members of the family experiencing Psychological illness to use Western Medicine either alone or together with Traditional Healing.
- Twenty two percent (2/9) of the respondents who are members of the AIC-Zionist grouping said they would encourage family members to use Faith Healing.
- Comparatively, there are no substantial differences between what respondents in this Christian grouping would do for themselves and what they would encourage members of their family to do when experiencing Psychological illness. They are marginally more inclined to encourage family members to use Western Medicine than they would for themselves.

Table 3.25: Frequency Distribution of the respondents by members of the AIC-non Zionist grouping to Variable Q23: Strategies for Psychological Illness for a member of the family.

	Count	Cumulative Count	Percent of Valid	Cumul % of Valid
Faith healing	2	2	25	25
Western medicine	3	5	37.5	63
Western & Traditional	1	6	12.5	75
N/A	2	8	25	100
Missing	0	8	0	

Textual summary

- Thirty seven percent (3/8) of the respondents who are members of the AIC-non Zionist grouping said they would encourage members of their family experiencing ***Psychological Illness*** to use Western Medicine. A further 13% (1/8) said they would encourage members to use Western Medicine together with Traditional Healing. Half of the respondents said they would encourage members of their family experiencing Psychological illness to use Western Medicine, either alone or together with Traditional Healing.
- Twenty five percent (2/8) of the respondents who are members of the AIC-non Zionist grouping said they would encourage them to use Faith Healing.
- Comparatively, what the respondents do when they experience ***Psychological Illness*** is different to what they would encourage members of their families to do. Considerably more respondents were inclined to encourage family members to use Western Medicine than they would for themselves. A shift by respondents is noticeable from a tendency to Faith Healing by respondents for themselves, to Western Medicine when encouraging family members.

		Respondents' Choices for Themselves				Respondents' Choices for Family Members			
		Types of Illness				Types of Illness			
Denominational Groupings ⇩	Health Seeking Strategies ⇩	Serious Physiological	Mild Physiological	Psychic Illness	Psychological Illness	Serious Physiological	Mild Physiological	Psychic Illness	Psychological Illness
Ecumenical Mission	Western medicine	56% (10/18)	72% (13/18)		55,5 % (10/18)	61% (11/18)	72% (13/18)	6% (1/18)	38% (7/18)
	Traditional healing	6% (1/18)		50% (9/18)	5,5% (1/18)	11% (2/18)		44% (8/18)	5% (1/18)
	Faith healing	11% (2/18)		17% (3/18)	11% (2/18)	5,5% (1/18)		22% (4/18)	11% (2/18)
	Western & Traditional	28% (5/18)	22% (4/18)	5% (1/18)	28% (5/18)	17% (3/18)	28% (5/18)	6% (1/18)	29% (5/18)
	Western & Faith					5,5% (1/18)			11% (2/18)
	Traditional & Faith			22% (4/18)				22% (4/18)	
	Western, Trad. & Faith								
	N/A		18% (1/18)	5% (1/18)					
AIC-Zionist	Western medicine	33% (3/9)	33% (3/9)		22% (2/9)		33% (3/9)		33% (3/9)
	Traditional healing		11% (1/9)	33% (3/9)	22% (2/9)		11% (1/9)	44% (4/9)	11% (1/9)
	Faith healing	22% (2/9)	22% (2/9)	22% (2/9)	22% (2/9)	11% (1/9)	22% (2/9)	22% (2/9)	22% (2/9)
	Western & Traditional	11% (1/9)			11% (1/9)	67% (6/9)	22% (2/9)	22% (2/9)	22% (2/9)
	Western & Faith					11% (1/9)			11% (1/9)
	Traditional & Faith			11% (1/9)					
	Western, Trad. & Faith	33% (3/9)	33% (3/9)	22% (2/9)	22% (2/9)	11% (1/9)	11% (1/9)	11% (1/9)	
	N/A			11% (1/9)					
AIC (Non Zionists)	Western medicine	25% (2/8)	37% (3/8)		12,5% (1/8)	12% (1/8)	50% (4/8)		37% (3/8)
	Traditional healing								
	Faith healing	50% (4/8)	37% (3/8)	37% (3/8)	75% (6/8)	50% (4/8)	25% (2/8)	75% (6/8)	25% (2/8)
	Western & Traditional					12% (1/8)			13% (1/8)
	Western & Faith	12% (1/8)	12% (1/8)		12,5% (1/8)	25% (2/8)	25% (2/8)		
	Traditional & Faith			25% (2/8)				25% (2/8)	
	Western, Trad. & Faith	12% (1/8)	12% (1/8)						
	N/A			37% (3/8)					25% (2/8)

Table 3.26: This table combines and consolidates all the small tables above

Textual summary

Ecumenical/Mission Churches

- In all the types of illnesses we have grouped for this study, Ecumenical Mission Churches rely heavily upon Western Medicine, except for Psychic Illness where there is a much stronger tendency to Traditional Healing.
- There are no proportional differences in what our respondents would do for themselves and what they would do for a sick family member with regard to any type of sickness we have grouped in this study.
- For Psychic Illness, there is a tendency to Traditional Healing, with a preference for Traditional Healing among half of our respondents.
- Mixing involves mainly Traditional Healing and Faith Healing. Respondents from the Ecumenical/ Mission Churches have little "faith" in Western Medicine when it comes to Psychic Illnesses such as spirit possession.
- For all other types of illnesses, mixing is mainly Western Medicine and Traditional Healing.
- In general Ecumenical/Mission Churches have little "faith" in Faith Healing for most types of illnesses that we have grouped for this study.

AIC-Zionist

- In this category of Christian grouping there is an even distribution of strategies.
- Like respondents from the Ecumenical/ Mission Churches, respondents in this grouping believe that Traditional Healing is a better choice for Psychic Illness like spirit possession, etc.
- Like respondents from the Ecumenical/ Mission Churches, AIC-Zionists also said they would not consider Western Medicine at all, except for a few (2/9) who said they would encourage their families to mix Western Medicine and Traditional Healing.

AIC (Non Zionists)

- There is a tendency among members of the AIC (Non Zionist) toward Faith Healing.
- They have no "faith" at all in traditional healing; they said they would never use traditional healing for any of the sicknesses that we identified. There are also very few cases where they said they would even consider mixing traditional healing with other strategies.
- In this grouping, when mixing occurs it is mainly between Western Medicine and Faith Healing.

3.4 Analytical summary of Christian grouping results

We have noted that in contrast to the other groupings, respondents from the Ecumenical Christian grouping tend to use less Faith Healing in all the types of illness we have identified in this study, with the exception of Psychic Illness. For instance when they experience Mild Physiological Illness, none of the respondents said they use Faith Healing either on its own, or together with other health seeking strategies. Both African Independent Churches (Zionists and Non-Zionists) have a much stronger tendency to use Faith Healing, though Non-Zionists tend to use it more exclusively than Zionists, who tend to combine it with the other two health seeking strategies.

This is one of the major contrasts between the African Independent Churches and the Mission Churches with European origin. There should be reasons for this contrast of behaviour; it might be the fact that the former emphasize faith more than the latter. In fact Faith Healing is commonly practiced in the African Independent Churches. It might also be, as has been argued elsewhere in this study, that one of the main reasons why people join African Independent Churches is that healing is provided. Among our respondents there were people who were members of Ecumenical/Mission Churches who also attend some African Independent Church's services for healing purposes, which supports this hypothesis.

We have also noted that all the Christian groupings made very little use of Western Medicine when they experienced Psychic Illness. In fact the few who did, would not use it on its own, but mixed it with other health-seeking strategies. By and large, Traditional Healing and Faith Healing alone or combined are the two dominant health-seeking strategies for Psychic Illness. This point to another dimension of mixing; that of adopting different strategies for different types of illness.

Once again we noted that Traditional Healing was prevalent among respondents of the Ecumenical/Mission grouping and Faith Healing among respondents of the African Independent Churches. None of the respondents said they used Western Medicine on its own for Psychic Illness.

Firstly, this points clearly to the fact that in spite of the predominance that Western Medicine enjoys and in spite of the amount of research that has been done in the field, it has failed to provide solutions to many key health problems for people in the groupings of this study. Secondly, this points to the fact that, in spite of the clandestine role occupied by the so-called "alternative strategies" during both the colonial and apartheid regimes, they are understood to be effective for certain illnesses.

This can be important for leveraging African religious health assets in the current health crisis. It also suggests that public health policy has ignored what is happening on the ground, and has therefore missed an opportunity to incorporate Traditional Healing as part of the mainstream health care system of South Africa.

The data suggests that most respondents in Christian groupings said they would do the same thing for members of their families as they would for themselves when they experience some of the illnesses we have identified. There are, however, exceptions.

Respondents of the AIC-Zionist group said they would encourage members of their families to use less Faith Healing than they would use themselves when they experience Serious and Mild Physiological Illness. As was suggested in the gender discussion, it might be the fact that they did not want to impose their Christian beliefs on members of their families. Clearly, further research needs to be done here.

AIC non- Zionist respondents were marginally more inclined to encourage members of their families to use Western Medicine on its own or with other health seeking strategies than for themselves with regard to Mild Physiological and Psychological Illness. Hence, one could assume that Faith Healing and Traditional Healing are regarded as 'unofficial' strategies with potential 'risks' in terms of their usage and accountability. Perhaps respondents are being cautious, being more ready to take 'risks' for themselves than for members of their families. As for encouraging members of their families to mix Western Medicine and Faith Healing, this may be expressing a protective attitude towards family members, e.g. encouraging them to get strong through Western Medicine to better prepare them for Faith Healing enemas.

Forms of mixing health care strategies varied. Ecumenical/Mission respondents mix mainly Western Medicine and Traditional Healing, with the exception of Psychic illness where they prefer to mix Traditional Healing and Faith Healing. AIC-Zionist respondents, when they mix, mainly prefer to mix all three health-seeking strategies across all illnesses, including Psychic illness. AIC non-Zionists prefer to mix mainly Faith Healing and Western Medicine, except in respect of Psychic illness.

3.5 Gender findings

We now turn to report on the second major variable discovered in this study, which is gender. We tested how gender influenced health-seeking behaviour of our respondents in relation to different types of illnesses we have identified for this study (see Table 26 underneath).

Table 26: Gender Table

		Variables															
Gender	Strategy	Q.16 Serious Physiological Illness		Q17 Mild Physiological Illness		Q18 Psychic Illness		Q 19 Psychological Illness		Q 20 Serious Physiological Illness (Family)		Q21 Mild Physiological (Family)		Q22 Psychic Illness (Family)		Q23 Psychological Illness (Family)	
Male	Western Medicine	7	47%	7	47%	0	0%	5	33%	3	20%	8	53%	1	7%	6	40%
	Traditional Healing	1	7%	1	7%	6	40%	2	13%	1	7%	1	7%	6	40%	1	7%
	Faith Healing	2	13%	3	20%	2	13%	4	27%	4	27%	2	13%	4	27%	2	13%
	Western & Traditional	4	27%	2	13%	1	7%	4	27%	5	33%	3	20%	1	7%	3	20%
	Western & Faith	1	7%	1	7%	0	0%	0	0%	2	13%	1	7%	0	0%	2	13%
	Traditional & Faith	0	0%	0	0%	3	20%	0	0%	0	0%	0	0%	3	20%	0	0%
	Western, Traditional & Faith	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	N/A	0	0%	1	7%	3	20%	0	0%	0	0%	0	0%	0	0%	1	7%
Female	Western Medicine	8	40%	12	60%	0	0%	8	40%	9	45%	12	60%	0	0%	7	35%
	Traditional Healing	0	0%	0	0%	6	30%	1	5%	1	5%	0	0%	6	30%	1	5%
	Faith Healing	6	30%	2	10%	6	30%	6	30%	2	10%	2	10%	8	40%	4	20%
	Western & Traditional	2	10%	2	10%	0	0%	3	15%	5	25%	4	20%	2	10%	5	25%
	Western & Faith	0	0%	0	0%	0	0%	2	10%	3	15%	1	5%	0	0%	1	5%
	Traditional & Faith	0	0%	0	0%	4	20%	0	0%	0	0%	0	0%	3	15%	2	10%
	Western, Traditional & Faith	4	20%	4	20%	2	10%	0	0%	0	0%	1	5%	1	5%	0	0%
	N/A	0	0%	0	0%	2	10%	0	0%	0	0%	0	0%	0	0%	0	0%

Textual Summary

Variable Q.16 Serious Physiological Illness (e.g. TB and Cancer)

- Roughly half of the male (7/15) and female respondents (8/20) said that when they experienced ***Serious Physiological Illness*** they used Western Medicine. A further 27% (4/15) of the male respondents used Western medicine together with Traditional Healing. And a further 20% (4/20) of the female respondents used Western medicine together with Traditional and Faith Healing. The vast majority[1] of the male and female respondents used Western medicine, or Western medicine together with other healing-seeking strategies.
- Thirty percent (6/20) of the female respondents used Faith Healing when they experienced ***Serious Physiological Illness***. A further 20% (4/20) used Faith Healing together with other health-seeking strategies. Thirteen percent (2/15) of the male respondents used Faith Healing when they experienced similar illnesses. A further 7% (1/15) used Faith Healing together with Western medicine.

Clearly Faith Healing was more prevalent among female respondents than among the male respondents when they experienced ***Serious Physiological Illness,*** with half of the female respondents using this strategy either on its own or together with Western medicine as opposed to a fifth of the male respondents.

Variable Q17 Mild Physiological (e.g. Common Cold or fever)

- Forty seven percent (7/15) of the male respondents said that when they experienced ***Mild Physiological Illness*** they used Western Medicine. A further 13% (2/15) used Western Medicine together with Traditional Healing. Sixty percent (12/20) of the female respondents said that when they experienced ***Mild Physiological Illness*** they used Western Medicine. A further 30% used Western Medicine together with the other health-seeking strategies. The large majority of the male and vast majority of female respondents used Western Medicine either on its own, or together with one or more of the other health-seeking strategies when they experienced ***Mild Physiological Illness.***

[1] In this section of gender findings 'majority' is categorized into three namely: 51%-65% (small majority), 66%-75% (large majority) and 76%-100% (vast majority).

- Twenty percent (3/15) of the male and 10% (2/20) of the female respondents used Faith Healing when they experienced ***Mild Physiological Illness.*** When compared with their responses to Serious Physiological Illness, a substantially smaller number of female respondents used Faith Healing for Mild Physiological Illness.

When they experience ***Mild Physiological Illness*** the female respondents are more likely than the male respondents to use Western Medicine either on its own, or together with other health-seeking strategies. In this regard Faith Healing is seldom used by the female respondents.

Variable Q 18 Psychic Illness (e.g. spirit possession)

- Forty percent (6/15) of the male respondents said that when they experienced ***Psychic Illness*** they used Traditional Healing. A further 20% (3/15) used Traditional Healing and Faith Healing. Thirty percent (6/20) of the female respondents said that when they experience ***Psychic Illness*** they used Traditional Healing. A further 20% (4/20) used Traditional Healing and Faith Healing. Thus half or slightly more of male and female respondents used Traditional Healing on its own or together with Faith Healing strategies.
- Thirteen percent (2/15) of the male respondents said that when they experienced ***Psychic Illness*** they used Faith Healing. A further 20% (3/15) used Faith Healing and Traditional Healing. Thirty percent (6/20) of the female respondents said that when they experience ***Psychic Illness*** they used Faith Healing. A further 20% (4/20) used Traditional Healing and Faith Healing.

When we compare these responses with the responses to both Serious and Mild ***Physiological Illnesses*** reported above we notice a clear shift away from Western Medicine to Traditional Healing and/or Faith Healing. Furthermore, the shift to Traditional Healing is more prominent among the male responses than female, and Faith Healing, as a single strategy, is more prominent among the female responses than male. Earlier we noticed that Faith Healing was a dominant strategy adopted by female respondents when dealing with ***Serious Physical Illness***.

Variable Q19 Psychological Illness (e.g. stress)

- Thirty three percent (5/15) of the male respondents said that when they experienced ***Psychological Illness,*** such as stress, they used Western Medicine. A further 27% (4/15) used Western Medicine together with Traditional Healing. Forty percent (8/20) of the female respondents said they used Western Medicine and a further 15% (3/20) used Western Medicine and Traditional Healing while 10% (2/20) used Western Medicine and Faith Healing.
- Twenty seven percent (4/15) of the male respondents said they used Faith Healing. Only 13% percent (2/15) of the male respondents said they used Traditional Healing. Thirty percent of female respondents said they used Faith Healing, and only 5% (1/20) said they used Traditional Healing.

The small majority of both the male and female respondents used Western Medicine either on its own or together with other health-seeking strategies when they experienced ***Psychological Illness.*** When we compare these responses with the responses to ***Serious and Mild Physiological Illness*** and ***Psychic Illness*** reported above, we note that Faith Healing is consistently more prevalent among female respondents and Traditional Healing among male respondents.

Variable Q20 Serious Physiological illness (member of the Family)

- Twenty percent (3/15) of the male respondents said they would encourage family members experiencing ***Serious Physiological Illness*** to use Western Medicine. A further 33% (5/15) would encourage family members to used Western Medicine together with Traditional Healing.
- Forty five percent (9/20) of the female respondents said they would encourage family members experiencing ***Serious Physiological Illness*** to use Western Medicine. A further 25% (5/20) would encourage family members to use Western Medicine and Traditional Healing, and another 15% (3/20) said that they would encourage family members to use Western Medicine and Faith Healing.
- A small majority of the male respondents would encourage family members to use Western Medicine either on its own or together with other health seeking strategies when experiencing ***Serious Physiological Illness***, whereas almost all the female respondents (95%) encouraged the use of Western Medicine, either on

its own, or together with other health seeking strategies. Male respondents would only encourage mixing of Western Medicine and Traditional Healing, whereas female respondents would encourage mixing of Western Medicine and Faith Healing.

When we compare the male responses on variable Q20 and variable Q16 we notice that male respondents are more inclined to use Western Medicine to treat Serious Physiological illness when they experience it personally than for their family members. Male and female respondents are not inclined to use Traditional Healing on its own. Significantly more male respondents (4/15; 27%) would encourage members of their family to use Faith Healing as a strategy to address Serious Physiological illness than they would for themselves (2/15; 13%). More female respondents (4/20; 30%) are inclined to use Faith Healing as a strategy to treat Serious Physiological illness for themselves than for members of their family (2/20; 10%).

This seems a bit contradictory when compared to how they responded when they themselves experienced the same illness. The confidence of male respondents to Western Medicine, either on its own or with other health seeking strategies, decreased, while the confidence of female respondents increased.

- Twenty seven percent (4/15) of male respondents said they encouraged family members experiencing ***Serious Physiological illness*** to use Faith Healing.
- Ten percent (2/20) of the female respondents said they encouraged them to use Faith Healing. A further 25% (5/20) encouraged them to use Traditional Healing together with Western Medicine.

Comparison of responses to the same question highlights a shift. Women had little confidence in faith healing when it comes to their families. Faith healing is more prevalent among male respondents than among female respondents, while Traditional Healing remains more predominant among male than female respondents.

Variable Q21 Mild Physiological illness (member of the Family)

- Fifty three percent (8/15) of the male respondents said that they would encourage family members experiencing ***Mild Physiological Illness*** to use Western Medicine. A further 20% (3/15) would encourage family members to use Western Medicine together with Traditional Healing. Sixty percent (8/20) of the female respondents said that when family members experience ***Mild Physiological Illness*** they would encourage them to use Western Medicine. A further 20% (4/20) encouraged them to use Western Medicine and Traditional Healing. The vast majority of both male and female respondents used Western Medicine, either on its own, or together with other health-seeking strategies when they experienced ***Mild Physiological Illness.***
- Thirteen percent (2/15) of the male respondents would encourage family members experiencing ***Mild Physiological Illness*** to use Faith Healing. Only 7% (1/15) encouraged them to use Traditional Healing. Ten percent (2/15) of the female respondents encouraged family members to use Faith Healing when they experienced ***Mild Physiological Illness***

There are no substantial differences between what they did for themselves and what they would encourage family members to do when experiencing ***Mild Physiological Illness*** although a slightly larger number of male respondents would encourage members of their family to use Western Medicine than would use it for themselves when they experienced the same illness.

Variable Q22 Psychic Illness like Spirit possession (member of the Family)

- Forty percent (6/15) of the male respondents said that they would encourage family members experiencing Psychic illness to use Traditional Healing. A further 20% (3/15) would encourage family members to use Traditional Healing and Faith Healing. Thirty percent (6/20) of the female respondents said that when family members experienced ***Psychic Illness*** they would encourage them to use Traditional Healing. A further 15% (3/20) would encourage them to use Traditional Healing and Faith Healing. The large majority of both male and female respondents said that they encouraged a member of their family to use Traditional Healing on its own, or together with other health seeking strategies.

When we compare the responses of males and females to questions about ***Physiological illness*** we note a shift from Western Medicine to Traditional Healing as the preferred health seeking strategy.

- Twenty seven percent (4/15) of the male respondents said that when a member of their family experienced ***Psychic Illness*** they would encourage them to use Faith Healing. Forty percent (6/20) of the female respondents said that when family members experience ***Psychic Illness*** they would encourage them to use Faith Healing

Clearly Faith Healing was prevalent among female respondents and Traditional Healing prevalent among male respondents though the difference is not huge. This is similar to the responses to ***Serious Physical Illness***.

Variable Q23 Psychological Illness like Stress (member of the Family).

- Forty percent (6/15) of the male respondents said they would encourage family members experiencing ***Psychological Illness*** to use Western Medicine. A further 20% (3/15) encouraged them to use Western Medicine together with Traditional Healing, and a further 13% (2/15) would encourage them to use Western Medicine and Faith Healing.
- Thirty five percent (7/20) of the female respondents said that when a member of their family experience ***Psychological Illness*** they encouraged them to use Western Medicine. A further 25% (5/20) used Western Medicine together with other Traditional Healing and a further 10% would encourage them to use Western Medicine and Faith Healing.
- The large majority of the male and female respondents used Western Medicine either on its own or together with other health-seeking strategies when they experienced ***Psychological Illness.*** It is noteworthy that a few more of female respondents encouraged their family members to use Western Medicine than they would do for themselves.
- Thirteen percent (2/15) of the female respondents encouraged members of their family to use Faith Healing when they experienced ***Psychological Illness***. Only 7% (1/15) encouraged them to use Traditional Healing.

- Twenty percent (4/20) of the female respondents encouraged members of their family to use Faith Healing when they experienced similar illness.

Once more, Faith Healing is prominent among female respondents, although the difference is not substantial. Faith Healing on its own was more prominent among Female respondents than Male respondents.

3.6 Analytical summary of gender results

With the exception of Psychic Illnesses both male and female respondents are more inclined to use Western medicine, either on its own, or together with other strategies when they experience different types of illnesses identified for this study.

With the exception of Mild Physiological Illnesses, Faith Healing is more predominant among female respondents than male respondents while Traditional healing is more prominent among male respondents than female respondents. The reasons for this pattern of behaviour are beyond the scope of this research; however, one might assume that more females are Christian believers than males, or that given the patriarchal nature of African societies, male respondents are more inclined to traditional methods of healing as an alternative to the pervasive use Western Medicine.

Among those who mixed types of health care, male respondents tend to combine Western Medicine and Traditional Healing while female respondents tend to combine all three health-seeking strategies (Western Medicine, Traditional Healing and Faith Healing) for all types of illnesses except for Psychological Illness and Psychic Illness. For the former we noticed that female respondents tend to mix Western medicine together with Traditional Healing or Faith Healing and for the latter we noticed that mixing is mainly combining Traditional Healing and Faith Healing for both female and male respondents.

We also note that there are no substantial differences between what our respondents do for themselves when they are sick, and what they would advise members of their

families in all types of illness, except for Serious Physiological illness. With regard to the latter, male respondents would encourage members of their family to use Faith Healing with greater frequency than they would for themselves, while female respondents would encourage members of their family to use less Faith Healing than they would themselves, and thus encourage them to use Western Medicine on its own or together with Traditional Healing or Faith Healing. Another noticeable change is that female respondents tend to encourage members of their family to combine Western Medicine and Traditional Healing, whereas there was a tendency to combine all three health seeking strategies for themselves. Reasons behind the change of behaviour are not covered in this study. We might assume that given the private and personal nature of religion, and the Christian faith in particular, they would not like to impose their Christian faith on members of their family who might hold different beliefs. In the case of Traditional Healing the scenario is a little different because it constitutes an indigenous worldview of health and illness, which people can easily associate and relate with. Further research needs to be done to clarify this.

Apart from the fact that the majority of all the respondents, male or female, are more inclined to use Western Medicine on its own or together with other health seeking strategies, we have also noticed the constant use of other health-seeking strategies on their own or together with Western Medicine. In spite of the few exceptions highlighted above, respondents, both males and females, would encourage members of their family to do the same thing as they would do for themselves. Overall we can safely state that gender does to some extent influence what respondents do when they are sick.

3.7 Relationship between Christian grouping and gender

The test of relationship between gender and Christian grouping was based on an argument that: If the variable Gender was more powerful than the variable Christian Grouping as a factor that influences the respondents' health-seeking behaviour, then where one gender is dominant among the respondents of one of the Christian Grouping categories, the health-seeking behaviour of that gender should also be reflected in that Christian Grouping's pattern of health-seeking behaviour. The result

indicate that the gender divide was fairly equal in all Christian Groupings except the Ecumenical Christian Grouping where female respondents were dominant. We then proceeded to test our argument using the Ecumenical Christian Grouping. Our findings are based merely on inspection of the results. The results indicate that Christian Grouping was more powerful than the Gender variable as a factor that influences the respondent's health-seeking behaviour.

CHAPTER 4

Competing or Complementary Worldviews

4.1 Main findings

At the start of this study we assumed; on the basis of general knowledge and anecdote, that medical pluralism is a widespread phenomenon among the target group, and that despite the predominance of Western medicine there remained the high likelihood that the target group would use more than one health-seeking strategy.

An important finding was that the variable Christian groupings, which classified the respondents into broad categories based on denominational affiliation, greatly influenced the respondent's health seeking behaviour. However the findings indicate vital differences between the different Christian groupings in terms of how they utilize different health-seeking strategies.

The Ecumenical/Mission grouping has a stronger tendency to Western Medicine than any other Christian grouping. The limited scope of this research did not allow further investigation of the reasons behind this pattern of behaviour. Nevertheless we might speculate that one of the reasons could be that churches falling into this category are European- or North American- founded churches, or that they are the so-called "Mission churches" because of their origins being linked to the advent of European Missionaries in Africa.

Typically, respondents from this Christian grouping, when mixing health-seeking strategies prefer to combine Western Medicine and Traditional Healing. This implies that these respondents, although largely influenced by the Western scientific worldview, are still marginally influenced by their indigenous culture/worldview, of which Traditional Healing is one component.

One particular finding was that an overwhelming majority of respondents are using multiple strategies, both for themselves and for their families. In the focus group we

conducted our respondents felt that as one of them stated "it is difficult to use one health-healing system for all the diseases that you encounter. Some illness cannot be cure by western medicine for those sicknesses you need to use Traditional or faith healing. Some of those illnesses are drop, fits *(Ukuxhuzula)*, spirit possession *(amafufunyana)*, being unable to bare children, etc."[2] Mixing occurs primarily in two different ways, namely: different strategies for different ailments (simple mixing), and more than one different strategies for a single ailment (complex mixing).

We have also established that Western Medicine is regularly used either on its own or in combination with other strategies. This is not surprising, given the fact that people are living in an industrialized society. However we have further discovered that some respondents use Western Medicine in a particular way. What emerged from the study is that Western Medicine is sometimes used by people who are weak; to better prepare themselves for Faith and Traditional healing enemas.

4.2 Choices and preferences

We now consider the research questions posed at the outset on the basis of the initial theoretical framework together with the data we collected. The three major preliminary questions we have asked in this research are:

i. What are the health seeking strategies of our population of study? (Which we have documented above in chapter 3)
ii. What factors are influencing the way people behave?
iii. Why are people using more than one health-seeking strategy?

4.2.1 The South African health system

When examining the ways in which people respond to their sickness experiences or behave when they are ill, it is imperative that we look at the health system, which is an embodiment or symbolic structure through which and upon which people react to illness. Bodeker (2001:01) highlights different possible health systems and

[2] Focus group

approaches that different countries tend to adopt throughout the world. The four broad forms of health systems highlighted are as follows:

i) a MONOPOLISTIC situation: in which modern medical doctors have the sole right to practice medicine;
ii) a TOLERANT situation: traditional medical practitioners, although not formally recognized are permitted to practice in an unofficial capacity;
iii) a PARALLEL or dual health-care system: both modern and traditional medicine are separate components of the national health system (e.g. India)
iv) an INTEGRATED system: modern and traditional medicine are integrated at the level of medical education and practice (e.g. Vietnam, China).

When we take a closer look at this broad picture generated by Bodeker we notice that pluralism of health systems is common around the world. The context in which people live is almost invariably pluralistic in some degree, and thus people have to choose between different health strategies, which are different forms of a particular health system. According to Lazarus, the South African health systems falls into the second category in that "it allows for separate systems to operate, but only officially recognizing one system - relegating the other(s) to 'informal' practices that are tolerated". (2004:23).

We have also noticed that 'health care pluralism' manifests in different forms in different contexts. As we have argued earlier in (Chapter 2) we notice that Bodeker further stresses that the concept medical pluralism is unhelpful, and he prefers to use "health care system" as opposed to medical care system. We have also noted that in all the forms that Bodeker highlighted, health-care pluralism is probably a worldwide phenomenon and it is also prevalent among our population of study.

However he also emphasises another notion, to which we have not given close attention in this study, namely: the nature of the relationship between health-seeking strategies, especially modern and traditional medicine. Bodeker seems to suggest that health-care pluralism is unique in each of its own different settings, and its uniqueness could be assessed by how different health-care strategies relate with one another in a particular social context.

So far we have explored a universal approach which could be applied anywhere, and have applied it even in a South Africa context by looking broadly developments at policy level. We described the South African situation as a tolerant situation, but have reservations regarding the latest policy developments that seek to give official recognition to traditional healing methods. It is pertinent that, before we go further in exploring and evaluating the factors associated with utilization and health-seeking behaviour that create health care pluralism, we should first describe paradigms in South Africa, or to be more specific, the Kayamandi health care system which is the context of our research.

4.2.2 Paradigms in Kayamandi health care systems

Our study was located in a context where there are parallel health care systems, which produces a plurality of health-seeking strategies, which in turn reflects the inequalities of the previous socio-political system. In fact, Lazarus (2004:69) states that the reality of the South African health system is that of "parallel systems which allow for three systems of health services to live alongside one another, but which does not yet give equal respect and resources to all three". People respond to ill-health by utilizing these three health-seeking strategies in a very selective and subtle manner.

There are three general expectations that would influence, guide or misguide our assumptions about what is likely to be happening in such a context, at least regarding the particular context of this research project. Firstly, given the fact that the majority of people living in Kayamandi are black African Xhosa speaking people, one would expect that the majority of respondents, if not all, would primarily utilize African traditional healing when experiencing any type of illness. Secondly, it is possible to assume that everybody would adopt Western Medicine for all types of illness because it is a dominant and officially recognised strategy, well resourced, accessible to all, as this is an urban township. And thirdly, on a subsidiary level, because all our respondents were Christians it would be reasonable to expect them to utilize Faith healing in greater numbers.

What emerged from the data collected in Kayamandi contradicts the assumptions made above about what could be expected there, and possibly in other similar contexts. Firstly, the health-seeking behaviour of our respondents was characterized by considerable mixing which validates our earlier argument that health-care pluralism is probably a common phenomenon. Secondly, this implies that, in spite of studying a group of Christians, and in spite of the similarity and common characteristics shown by our population of study, the behaviour varied. It reflected many aspects, namely: Christian affiliation, gender and personal or cultural convictions. The pattern of behaviour revealed by the data seems to suggest that our respondents live a complex parallel life style of being Christians, and black Africans, in an industrialised society. Through what Lazarus describes as 'border crossing', they utilize all three health-seeking strategies with minimal conflict.

4.3 Alternative health care

In South Africa there is one official recognised health strategy to which all others are alternative, and that is Western medicine. The patterns of behaviour that emerged from the data contradict and challenge how we view alternative health care.

The term *"alternative"* is a loaded, term particularly with reference to our field of study. When we refer to *alternative* health care, it is not clear whether we are referring to a different optional health strategy where a first choice health strategy failed, or whether we are referring to an alternative choice that is adopted without first considering a prior choice health strategy. Furthermore it is also not clear whether "*alternativity"* is a fixed or standard condition. In other words, all other health-seeking strategies are alternative to a dominant and conventional strategy, and thus relatively defined.

This can be problematic, because it could undermine the dominance of other strategies like Traditional healing and Faith healing in application to illnesses such as Psychic illness to which Western medicine then becomes the alternative. White

(2000:02) states that "alternative medicine consists of (a) a comprehensive medical system based on alternative paradigms for understanding health and illness to Western orthodox Medicine's biomedical model or (b) if partially or wholly understood from a biomedical perspective, medical systems that provide alternative modes of treatment to those comprising standard medical or psychological practice in the United States". He states further, "Alternative medicine implies practices that constitute alternatives to conventional medicine, whereas complementary medicine connotes treatment thought of or used as adjunct to conventional medicine".

The literature does not give a clear distinction between the terms alternative and complementary medicine, and in this research we have used these terms concurrent and interchangeable. In spite of contest and conflict of definition of these terms, we have established that our respondents utilise health-seeking strategies in both the alternative and complimentary way. For instance, when respondents from the Ecumenical grouping said they used Traditional and Faith healing when experiencing serious physiological illness, these were an alternative to value laden Western medicine. When they said that they utilised Western medicine when they are weak to withstand Faith and Traditional healing enemas, Western medicine is then used in a complimentary way.

Other scholars expound this further and argue, "the term complementary medicine broadly describes any health approach that is not part of the conventional medical approach of a particular society or culture" (Health wise, 2004:12). Han (2002:02) argues that both terms 'complementary' and 'alternative' are problematic. He states, "some writers argue that complementary therapy is the alternative to the 'troubled' or unsatisfactory biomedicine and so prefer to call this field 'alternative medicine' or 'alternative therapy.' Others argue that the term 'complementary therapy' is more appropriate as it is hoped to complement biomedicine rather than replace it. This also signifies the acceptance that complementary medicine can work together with biomedicine".

Both of the terms, complementary and alternative medicine, are problematic. Behind the concept of complementary medicine is the idea that a combination of biomedicine and complementary medicine forms holistic medicine. The concept is still open to debate. In addition, the term 'alternative medicine' assumes that we always have an alternative therapy to biomedicine, which is clearly not true."

We have observed that the data collected questions the permanent status of alternative health-care. For example, most of our respondents from all three of the Christian groupings identified, said that they would adopt an alternative health strategy (only) "when they do not get better or become seriously ill" regardless of their first choice health strategy. Significantly, we have evoked mixed responses when we asked where respondents usually go first to seek help when they are sick. About half of the total respondents cited Western medical doctors as their first choice, followed by about a quarter who gave Faith healing as their usually first choice. Similarly, close to a quarter of respondents said that first choice strategy 'depends on the type of illness I have'; just less than a quarter did not respond to the question. These respondents are very selective in their approach because they adopt a particular strategy for a specific type of illness. This implies that they vary health-seeking strategies in response to the type of illness they experience.

This implies that we need to be careful about which health strategies we refer to as alternative strategies. If for certain illnesses such as psychic illness respondents would adopt only alternative health strategies to the exclusion of the Western conventional medicine, and if the majority of respondents from the AIC-non Zionist Christian grouping said they would use Faith Healing exclusively when experiencing psychological illness, then the status of "alternative" health care needs to be revisited. This means that what is considered alternative to one group can be conventional to others and vice versa.

In a subtle way Bodeker (2001:01) affirms our argument when he states, "according to the World Health Organization (WHO), traditional health care systems constitute the main source of everyday health care for the majority of the population of most

developing countries - up to 80% of many countries. They also serve the health care needs of the indigenous population in industrial countries such as Canada, Australia and New Zealand. The ratio of traditional health practitioners to population can be substantially higher than the ratio for trained medical personnel, thus representing an irreplaceable health care infrastructure. At the same time, most traditional systems are outside the formal health sector or often have marginal status, if officially represented". Therefore it would seem appropriate to argue that "what is considered 'complementary' or 'alternative' varies from culture to culture" (Health wise, 2004:179)

In view of these considerations, we are left to emphasise Bhikha's (2002:01) question: "is alternative medicine really alternative?" In an exploratory note he argues "The meaning of the word 'alternative medicine' from the Oxford Dictionary refers to any range of medical therapy that is not regarded as orthodox by the medical profession. It is therefore obvious that alternative medicine is considered alternative by first world consumers for whom western orthodox medicine is their first choice. For most people on the planet, modern allopathic medicine is actually the alternative, especially in the developing countries of the world".

He further states that "In South Africa, where I come from, whilst modern medicine is firmly entrenched with all the sophistication of technology, surgical procedures, trauma care and hospitalisation, more than 70% of the population still makes use of African Traditional medicine using indigenous herbs and traditional practices of medicine"(2002:02).

The section that follows carries an evaluation of the three factors describe by Han that influence the choice of health-seeking strategy, and thus make health care pluralism feasible.

4.4 Factors influencing health seeking behaviour

4.4.1 Accessibility and availability

Firstly, Han (2002:03) argues that "non-orthodox healers may be more easily accessible geographically and financially", which implies that he assumes, that the use of non-orthodox healers has something to do with accessibility. In contrast to Minocha's (1980), Han's (2002) and Stock's (1987) theoretical hypotheses discussed earlier in (Chapter 2), which led us to make the same assumption - that simply because the context of our research is urban or peri-urban, where people could be expected to rely to Western medicine because it is available and easily accessible, we observe a wide use of other health-seeking strategies as well.

This means that there is a shift towards alternative approaches that challenges an old order as expressed by Bodeker (2001:01), quoting Cunningham that "While traditional health systems in developing countries have typically been the primary health service of rural communities and the poorest levels of society, there is now increasing reliance on traditional health-care by urban populations as well." (Cunningham, 1993).

Bodeker further states, "In Africa, the rapid rate of urbanization is changing the face of traditional medicine. Where previously, the village herbalist or healer would provide services and would draw on nearby forests and fields for herbs, urban markets have many herb sellers, each giving advice and many selling both raw plant material and preparations that they have produced themselves. Quality control is a challenge under these circumstances" (2001:01).

In spite of the accessibility and availability of Western Medicine, people do adopt other health seeking strategies. Notwithstanding the limitations of this research, we can safely argue that the choice of health seeking strategy transcends accessibility and availability. This research suggests that the choice of strategy by respondents has nothing to do with the distance to the Western type-health facility, because even though it is more accessible and easily available to them, our respondents do utilize alternative medicine for certain illnesses.

4.4.2 Conflicting worldviews

Secondly, Han's (2002:03) premise is that "patients may consult non-orthodox health-seeking strategies because they do not always agree with unfavourable comments made about them by orthodox medical doctors".

The present study reveals that the utilization of non-orthodox health strategies is deeper than this. Although health-seeking strategies are still kept apart to the extent that there is minimal contact and few referrals between them, the data nevertheless show that people develop ways of living across these worldviews in order to solve illness problems and to develop a more responsive health care system. Although there is a struggle and conflict of worldviews and approaches to health, respondents seem to recognize the value of each, and understand when and how to use them selectively.

It seems that respondents are less influenced by what each strategy says about the other than they are influenced by their own gender, cultural and Christian conviction, and their understanding of illnesses. Some of the reasons cited for adopting conflicting worldviews were: 'when one strategy does not work and 'when they become seriously ill'. The majority of respondents said they mix strategies when one strategy does not work, and the majority's first choice strategy is Western Medicine.

4.4.3 Combining all approaches

Thirdly, Han's (2002:03) contention is that "people may be interested to take up any health service available in the hope that they may provide relief". This study shows that this pattern of behaviour was more prevalent among members of AIC-Zionist and female respondents of all groups. Although respondents in some limited instances opted to use any health strategy in the hope of finding relief, the study reveals that respondents have developed opinions regarding which strategy they believe should be adopted for which type of illness. Their freedom of choice and preference is informed by their understanding of health and illness.

4.5 Why are people mixing?

The literature highlights different reasons why people use and mix alternative health-seeking strategies. Han (2002:13) quoting (Baer et al., 1998), (Sacks, 1994), (Daykin, 1996) (Coward, 1989;) (Goldstein, 1999;) and (Sharma, 1990, p. 132) states that "Increasing popularity of complementary medicine in recent years is in part due to people's dissatisfaction with biomedicine and thus poses a very real challenge to it." He goes on to state "this is a clear indication of some of the gaps within conventional medicine".

Research suggests that "the users of alternative medicines are not only aware of biomedicine's inability to cure many illnesses, but also they are not always satisfied with the biomedical treatments offered. Moreover, biomedicine is seen as insensitive to the needs of individual patients and that it does not appropriately handle the social and experiential aspects of illness." (Han, 2002:17) The data we collected suggests that our respondents understand the strength of each health-seeking strategy, including that of Western medicine and thus are aware which strategy they should utilize for which type of illness.

One wonders if people's understanding, choice and preferences are reflected at the policy level. Lori, Colomeda and Wenzel (2000:247) seem to advocate that alternative health-care needs to be taken seriously when they argue that "if we consider the profession of Western medicine today, it is clear that its major characteristic is pre-eminence, such pre-eminence is not merely that of prestige, but also that of 'expert authority' and power". They go further to state (quoting Freidson, 1970, 7) that "Western medicine's knowledge is considered to be authoritative and definitive, provided by 'professionally trained experts of accredited institutions of tertiary education'. Western medicine assumes pre-eminence because it believes in scientific rationality of the European kind. It claims that its paradigm of scientific conduct is the only thing that merits acknowledgement by everyone living on Mother Earth".

Lori, Colomeda and Wenzel (2000:247) highlight that there are differences in Western and indigenous conceptions of health when they state, "when writing about indigenous health, we reflect on the practices of indigenous people i.e. on their oral

and behavioural tradition. Especially we refer to the balance between body, mind, spirit, culture and earth and conclude that when these elements are in balance, we may enjoy good health". This seems to suggest that these practices need to be recognized and leveraged because they are important aspects required to achieve complete health.

One of the reasons given by our respondents for mixing health-seeking strategies is the failure of the initially chosen strategy. Some respondents said they first use Western medicine, and when it does not work opt for, or use it with another health-seeking strategy. However, it is not clear whether those who identified their first choice strategy as Western medicine based that on conviction of experience or are merely influenced by the pre-eminent reputation of Western medicine. Some of the respondents who were selected for in-depth interviews claim to have long history of illness with different kinds of illnesses like Asthma, stomachaches, waist problems and fits. Most of them said they started seeking help from Western Medicine but when they saw that it is not helping them they started searching for alternatives.

Analyzing Airhihenbuwa's (1995:50) contention of the religious dimension of health, it would appear that one of the reasons why people mix health-seeking strategies is the desire for complete health, 'the fullness of life'. He seems to suggest that health has different dimensions, of which spirituality is one when he argues, "Religion is critical to an understanding of the spiritual dimension of health which in turn is pivotal to the maintenance of the psychosocial dimension of health", and further states "in other words, there is more to health-care than medical care. Health-care delivery systems do not exist in and of themselves, but as parts of larger socio-cultural wholes. Health care systems comprise a set of resources that may serve non-medical as well as medical goals".

Our reading of history indicates that we have focused on the medical goals at the expense of the resources that seek to serve non-medical goals. How people utilize health-seeking strategies, and what illness signifies against a backdrop of a desire for a complete health deserves more attention. The implication is that each health-seeking strategy has it own idiosyncratic role to play in every person's individual sense of well-being. This also means that each medicine has strengths and weaknesses. No medicine can help every patient with every disease. For example, as opposed to a

group of respondents who said they mix because one strategy does not work, we had a group of respondents who said that they mix when they are seriously ill and weak; they first go for Western Medicine to better prepare themselves for Faith and Traditional Healing enemas. This was further confirmed by the respondents we interviewed one of them stated that "when you are too weak (*iziwatsho*) enemas used by faith healers are not good because they are too strong for weak people so that is why some people choose to go to the doctor first then use his or her traditional of faith healing enemas."[3]

Airhihenbuwa's argument that "historically, traditional healers were specialists at a time when allopaths were generalists" (1995:54) seems to be a justifiable perception when we take note of how respondents choose health-seeking strategies for different types of illnesses. For example, all our respondents from each Christian grouping said they would make very little use of Western Medicine when experiencing Psychic illness. This seems to suggest that the African traditional healing strategy has adequate knowledge in certain aspects of health care, and thus Airhihenbuwa (1995:57) states that "though deficient in some areas, traditional healers could be donors in other areas in which they are known to be efficient and effective, healers are encouraged to surrender their herbal lore for the advancement of science".

All of this suggests that, as Han (2002:10) has argued people "have turned to realize and question the effectiveness of modern medicine in alleviating the diseases patterns in the advanced capitalist society". In fact the heroic nature of Western medicine contributed to people's realization of its limited efficacy because they expected too much from it. Over and above what is reflected in the literature, the data reveals that religious beliefs are strongly influential in determining the choice of strategy. However, some people attribute the resurgence of traditional and religious ways of healing to public health demands with which Western medicine failed to cope.

[3] In-depth interview notes

4.6 A model for health seeking behaviour

Above we have demonstrated that our research contradicts some of our earlier theoretical assumptions. Our investigation revealed that access and availability did not influence the choice of strategy, leaving the way open to speculation about other possible factors that influence people's behaviour in this regard. The research suggests that people are largely influenced by their Christian group affiliation, and to some extent gender has an influence.

The data also demonstrates that people's experiences also influence and determine which strategy they adopt, for example when most respondents from all the Christian grouping said they would not use Western Medicine on its own when they experience Psychic Illness. In fact, even those few who would use Western medicine, would not use it on its own.

During the interviews we conducted with the few selected respondents, we observed that they believe that Western Medicine is not effective or satisfactory when it comes to Psychic illness. The reasons for this kind of behaviour are not clearly understood. Does it highlight the shortcoming of the allopathic medicine as Bhikha (2002:01) suggested: "the increase in alternative treatments like hands-on as well as energy and psycho-spirit treatment highlights the shortcomings of the allopathic modern medicine that focuses on technology and data-base patient evaluation and in so doing lost the personal touch and a more holistic approach to healing", or does it suggest that not all illnesses require sophisticated technology, surgical procedures, trauma-care and hospitalization as employed by Western Medicine?

After highlighting some of the shortcomings of modern medicine, which could be demonstrated by health-seeking behaviour that rejects modern medicine for some illnesses, Bhikha (2002:03) concludes that "a more holistic approach towards the patient's needs is one of the challenges faced by modern medicine today". He goes on to state that, "whilst technological advancements have provided valuable insights into diagnostic and biochemical information, the wisdom of the traditional systems of

medicine, which can easily be integrated into the practice of medicine, should not be overlooked".

4.6.1 Living in more than one world

Health care pluralism, which is the inner core of the thesis of this research, implies that people are living in more than one world. In other words people are faced with contrasting, alternative and sometimes complementary worldviews. The challenge for people is how they choose to respond to the clash of different worldviews.

Ambler (1994:01) describes this as the 'cultural war' when he comments that, "relying upon traditional knowledge and native plants, indigenous people have been treating illnesses successfully for thousands of years. After the arrival of Europeans on this continent however, medicine became one of the battlefields in the cultural war". He further states that, "both patients and students of healing had to choose between traditional practices and Western medicine. Patients who used herbs or went to medicine people felt compelled to keep that secret from their Western doctors, who wanted to focus upon treating the patient's body without regard for the mind or spirit".

As if the paradox of the time was not enough, it was further aggravated by the fact that the battlefields were not levelled. Bodeker (2001) elucidates this by saying "in colonial settings, traditional health systems were frequently outlawed by authorities. In post-colonial times, medical attitudes and stereotypes have served to maintain the marginal status of traditional health care providers, despite their role in providing basic health care to the rural majority of developing countries". In contrast, Comaroff & Commaroff (1997: 363) state that "in the post-colonial epoch, more generally, with doubts growing about the supremacy of Western biomedicine, there has been a new attitude of open curiosity toward alternative healing".

During the course of the nineteenth century the demand for Western remedies was high; however "these were not simply taken over, displacing indigenous counterparts. From the first, the two therapeutic traditions were imbricated in a complex equation of

exchange and synthesis. The result, a rich hybrid field of healing techniques, refracted, as we would now expect, along the lines of social difference taking shape at the time" (Comaroff & Camaroff, 1997: 360). This suggests that even during the nineteenth century people established ways of responding to and coping with health care pluralism and some of the main ways as described by Commaroff & Camaroff was an equation of exchange and synthesis. Investigation of the ways in which people are currently responding to the 'clash' of different worldviews is crucial.

4.6.2 Serial and Simultaneous use of competing strategies

In this section we respond to two major questions of this study: What does the target group do to get well when they are sick, i.e. what health-seeking strategies does the target group adopt, and why?

Lazarus, informed by different authors, summarizes different ways in which people respond to the challenge of living in 'two worlds'. She states that (a) "it includes living in one or other of the two worlds e.g. assimilating or integrating into the dominant culture at the expense of one's own culture or pursuing a totally 'indigenous' or 'traditional way of life rejecting the dominant Anglo-Euro-American culture; (b) living some kind of parallel life in 'two' (or more) worlds, which can be done successfully through 'border crossing' - where a person accommodates and reconciles but does not assimilate - or is often done less successfully with internal and external conflicts creating major personal and social problems for the people concerned; or (c) integrating different worldviews by creating new traditions and worldviews from some kind of hybrid 'mixture' of worldview" (2004:23).

The data suggest that our respondents fall to category (b) as described by Lazarus. They live a parallel kind of life marked by serial and simultaneous or exchange and synthetic use of health-seeking strategies. The data also reveal that about 40% (15 of 35) respondents use different health-seeking strategies simultaneously for a single ailment, that is, what we referred to earlier as 'complex mixing'. Simultaneous use is often marked by a serial and synthetic approach.

In the case of the former, respondents mix health-seeking strategies but in a serial manner; they said they do not treat those strategies as equivalents or equal; they therefore use one first, and if it does not work, then the other. Typical of this set of respondents' behaviour is that the first strategy they adopt is Western Medicine, especially when they are seriously ill and weak, so that they can become strong enough to withstand the Faith Healing and Traditional Healing enemas.

This was more prevalent among AIC-Zionists and among female respondents, though it was present among other Christian groupings as well. Bodeker (2001:2) calls this 'symptomatic relief' and he states "cultural factors also play a significant role in the continued reliance of rural communities on traditional medicine, which is familiar and trusted. For example, villagers will often seek symptomatic relief from modern medicine, while turning to traditional medicine for treatment of what may be perceived as the 'true cause of the condition'".

This means that in some instances people make a simultaneous use of different strategies because they feel that each strategy has its own role to play in their well-being when they are sick. In the case of the synthetic approach, respondents said they treat health-seeking strategies as equal when they are mixing. In the focus group we conducted, respondents highlighted dangers in using different health-seeking strategies simultaneously. Apart from the health risk they anticipate and fear, they highlighted a fear of not knowing which one helped, which they believe is crucial knowledge for future reference.

We also had respondents who adopt an 'exchange equation/approach'. These respondents tend to adopt different strategies for different types of illnesses. These types of respondents are common in all types of Christian groupings, especially when taking into consideration what they say they would do if they experience Psychic illness, which differs markedly from their responses to all other illnesses.

The survey data indicates that there is no single way of mixing health strategies; this was also indicated by respondents who were interviewed in-depth, and in the focus group. The views are contrasting on whether mixing strategies is problematic or not. One of them said "There is no problem in mixing health seeking strategies. I was a

TB patient I took treatment from the clinic and use enemas from my Faith Healer I am fine there were no complications or problems."[4]

Contrastingly those who assembled for the focus group believe that "mixing health seeking strategies can be dangerous as a result they do not mix. They state that you can go to the one first and you give it 4-6 days if it does not work you go to the other one. Once you have medication from the second one you stop using the first medication you keep it and not use it simultaneously with the other. If it does not help you can go back to the first medication."[5]

4.7 Religious and cultural aspects of health

Researchers like Pillay (1995), Bodeker (2001), Yee, B.W.K. & Weaver, G.D. (1994) and Airhihenbuwa, C. O. (1995) all argue that cultural factors play a significant role in the persistent reliance of people on alternative healing methods. This research seems to suggest that, over and above culture, there is an evolution of 'other' religious practices in the form of Christianity.

Almost all of our respondents have strong rural links and they do not regard Cape Town as their home, and yet they spend most of their lifetime here. Some of the cultural and ritual practices they ought to practice can only be conducted in their homes in the Eastern Cape. These practices have a strong local and family reliance, which means most people find themselves dislocated and consequently disoriented when they are in the urban areas. Churches have proven to be the strongest support system for these people, which could account for the rise and impact of Christianity in an urban township like Kayamandi.

Cochrane (2003:11-12), quoting Martin, also notes analogously the role of the church from a Latin American context where "Pentecostalism renews the innermost cell of the family and protects the woman from ravages of male desertion and violence. A

[4] In-depth interview notes

[5] In-depth interview notes

new faith is able to implant new discipline, re-order priorities, counter corruption and destructive machismo and reverse the indifferent and injurious hierarchies of the outside world.... millions of people are absorbed within a protective social capsule where they acquire new concepts of self and new models of initiative and voluntary organisations"

4.8 Conclusion

It seems that health care pluralism is inevitable. About 80% of all of our respondents, when asked if mixing health-seeking strategies is helpful or not, said, "it depends on the type of illness you have". This means that for certain types of illnesses it might not be helpful whereas for some it could be helpful.

This research has explored and exposed some of the factors influencing the use of a variety of treatment strategies as alternatives to, or in combination with, Western medicine. Fundamentally, the resurgence of "alternative medicine" is a reflection of the limitations of Western medicine in curing all types of illnesses effectively. It also shows that there is a need to exploit and promote religious health assets that were discredited under the dominant influence of Western medicine. It can also be said that the emergence of the African Independent Churches brought another dimension of health-seeking strategy in the form of Faith healing.

The data reveals that most of the respondents who belong to the Ecumenical/Mission grouping, which historically pre-dates the origin of the AICs use Western Medicine at higher frequency levels than any other Christian grouping identified.

We have also found that the choice of strategy is not only determined by which strategies are available to people, but also by others factors such as conviction of experience and knowledge of health and illness.

Bibliography

Airhihenbuwa, Collin O. (1995). *Health and Culture: Beyond the Western Paradigm.* Thousand Oaks, Calif: Sage Publications, Inc. Thousand Oaks, London and New Delhi.

Ambler, M. (1994). "Making room for tradition: Tribal Colleges blend the wisdom of traditional healers with the science of Western Medicine". *Tribal College of American Indian Higher Education*, 5 (3): 17-20.

Babbie, E & Mouton, J. (2001). *The Practice of Social Research.* South African Edition, Cape Town: Oxford University Press.

Bate, S.C. (2001). "An interdisciplinary approach to understanding and assessing religious healing in South African Christianity". *Missionalia*, 29 (3): 361-386 (November).

Bate, S.C. (2002). *Human Life is Cultural*. Pietermaritzburg, South Africa: Cluster Publication.

Bhardwaj, S.M. (1980). "Medical pluralism and homeopathy: a geographical perspective." *Social Science & Medicine,* 14B (4): 209-16.

Bhika, R. (2002). "Is Alternative medicine really alternative?" Paper presented at the 38th International Congress on the History of Medicine held on the 1-5 September in Istanbul, Turkey.

Bodeker, G.C. (2002). *Traditional Health Systems and National Policy*. London: Research Council for Complementary Medicine.

Byron J. & Mary-Jo Del Vecchio Good. (1993). "Learning medicine: the construction of medical knowledge at Harvard medical school". In *Knowledge, Power & Practice: the Anthropology of Medicine and Everyday Life,* Shirley Lindenbaum & Margaret Lock, (Eds). Berkeley: UCLA Press, 81-107.

Comaroff J.L. and Camaroff Jean. (1997). *Of Revelation and Revolution. The Dialectics of Modernity on a South African Frontier*. Vol. 2. United State of America: University of Chicago Press.

Cochrane, J. R. (2003). "Religion in the Health of Migrant Communities: Asset or Deficit?" University of Cape Town (unpublished paper).

Cochrane, James R; Gunderson, Gary; McFarland, Deborah; Schmid, Barbara. (2003). "ARHAP Guide: Concepts and Theory." African Religious Health Assets Programme, University of Cape Town (unpublished document).

Colomeda, LA. & Wenzel, E.R. (2000). "Medicine keepers: Issues in indigenous health". *Critical Public Health.* 10(2), 243-256.

Dawes, A & Honwana, A. (1996). "Children, Culture and Mental Health: Interventions in Conditions of War". In *Children, War and Persecution- Rebuilding Hope*, Proceedings of the Congress in Maputo, Mocambique, 1-4 December. Special edition, *Rebuilding Hope.*

Farmer, Paul. (2003). *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Berkeley: University of California Press.

Gibbs, A. "Focus Groups" in *Social Research Update*, issue 19, University of Surrey. (http://www.soc.surrey.ac.uk/sru/SRU19.html) 15/13/03

Good, C. M. (1987). "Community health in tropical Africa: Is medical pluralism a hindrance or a resource?" In *Health and Disease in Tropical Africa: Geographical and Medical Viewpoints,* Rais Akhtar, (ed.). London: Harwoord Academic Publishers, 13-50.

Green, E. C, (1988), "Can collaborative programs between biomedical and African Indigenous health practitioners succeed?" *Social Science and Medicine.* 27:1125-1130.

Han, G. (2002) "The Myth of medical pluralism: A critical Realistic Perspective" *Sociological Research Online.* Vol.6 (4). (http://www.socresonline.orguk/6/4/han.html).

Holmes K.K et al, (Eds). (1999). *Sexually Transmitted Diseases*. New York, McGraw Hill, (3rd Ed).

International Religious Freedom Report (2002), U.S Department of State: Bureau of Democracy, Human Rights and Labour (http://www.state.gov/g/drl/rls/irf/2002).

Jansen, G. (2001). "The labyrinth of Medical Pluralism in Africa: A Missiological Appraisal, AD", *Missionalia.* 29 (1) (April), 69-91.

Lazurus, S. (2004). "An exploration of how native American worldviews, including healing approaches, can contribute to and transform support service in education" *Research report for Filbright Commission, S.A. National Reserch Foundation: (Indigenous Knowledge systems), and University of the Western Cape.*

Lee, H. J. J. (1996). " Transforming Society, Transforming medicine: Lay Medical Perceptions and Self-medication among contemporary Koreas" in *Society, Health and Disease*: *Transcultural Perspectives*, Subedi, J. & Gallagher E. B (Eds). Upper Saddle River, N.J.: Prentice-Hall.

Leslie C. (1980) "Medical pluralism in world perspective", *Social Science and Medicine.* 14b (4): 191-5.

Minocha, A. A. (1980). "Medical pluralism and health services in India". *Social Science and Medicine.* 14B (4): 217-23.

Neuman, W. L. (1998). *Social Research Methods: Qualitative and Quantitative Approaches.* Boston: Allyn and Bacon

Ngubane, H. (1981). "Clinical Practice and Organization of Indigenous Healers in South Africa", *Social Science and Medicine.* 15B: 361-66.

Owoahene-Acheampong, S. (1998). *Inculturation and African Religion: Indigenous and Western Approaches to Medical Practice.* New York: Peter Lang.

Pals, Daniel L. (1996). *Seven Theories of Religion*, New York, N.Y: Oxford University Press.

Pearce, T.O. (1993). "Lay medical knowledge in an African context". In *Knowledge, Power & Practice: the Anthropology of Medicine and Everyday life*, Shirley Lindenbaum & Margaret Lock (Eds). Berkeley: UCLA Press, 150-165.

Perdu, B. (2002). The South African Economy and Developmental Problems, Kayamandi: a Township as a Social, Economic Entity, University of Stellenbosch, (unpublished research).

Pillay, B.J. (1996). "A model of help-seeking behaviour for urban blacks". *South African Journal of Psychology.* 26 (1).

Pilch, J. (1996). "Book review Inculturation & Healing: Coping-Healing in South African Christianity". in *Hervormde Teologiese Studies.* 52: 205-210. (http://www.georgetown.edu/faculty/pilchj/bate.htm).

Press, I. (1980). "Problems in the definition and classification of Medical Systems" In *Social Science and Medicine.* 14B (4): 45-57.

Saayman, W. (1992). "AIDS, healing and culture in Africa". *Missionalia.* 27 (2) (March).

Saayman, W. (1999). "Aids - still posing unanswered questions". *Missionalia.* 27 (2) (August).

Seale, C., and Pattison, S. (1994). *Medical Knowledge: Doubt and Certainty.* Philadelphia: Open University Press in association with the Open University.

Shriver, D. W. (1980). "The interrelationships of Religion and Medicine". *Medicine and Religion: Strategies of Care,* Shriver D. W. Jr. (ed). (Pittsburgh: University of Pittsburgh Press, 21-45.

South African Year Book. (2002-03). Pretoria, South Africa: Government Communication and Information System (GCIS).

Stock, R. (1987). "Understanding Health Care Behaviour: A model, Together with Evidence from Nigeria". In *Health and disease in tropical Africa: Geographical and medical viewpoints,* Rais Akhtar (ed). London: Harwoord Academic publishers, 279-92

Strauss, A & J. Corbin. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, Newbury Park, Calif.: Sage.

Van Rensburg, H. C. J., Fourie, A., Pretorius E. (1992). *Health Care in South Africa: Structure and Dynamic.* Pretoria: Academica.

White, K.P. (2000). "Psychology and complementary and alternative medicine". *Professional Psychology: Research and Practice*. 31 (6), 671-681.

Yee, B.W.K & Weaver, G. D. (1994). "Ethnic Minorities and Health Promotion: Developing a 'Cultural Competent' Agenda". *Generations*. 18 (1).

UNIVERSITY OF CAPE TOWN

A research project on the *health-seeking behavior* of the Xhosa-speaking people in a Black Township in South Africa.

Name .....
Address .....
.....
.....
Telephone .....

SURVEY QUESTIONNAIRE

Q.1 **Uzalelwe phi?**
Where were you born?
.....

Q.2 **Uzalwe ngawuphi unyaka?OKANYE Mingaphi iminyaka yakho?**
When were you born? OR How old are you?

.....

Q.3 **Ukuba uzalelwe kwenye indawo ufike nini ukuza kuhlala apha eKapa?**
If you were born somewhere else when did you arrive and settle in Cape Town?

.....

Q.4 **Ingaba iKapa uyithatha njenge Khaya lakho ngokupheleleyo?**
Do you regard Cape Town as your home, completely?

Ewe		**Hayi**		**Andiqinisekanga**	
Yes	☐	No	☐	Not Sure	☐

Q.5 **Ukuba iKapa akuyithathi njengeKhaya yeyiphi indawo oyithatha njengeKhaya?**
If you do not regard Cape Town as your home, where do you regard as your home?

.....

Q.6 **Xela isini sakho?**
What is your gender?

.....

Q.7 **Loluphi ulwimi lwakowenu?**
What is your mother language/first language?

.....

Q.8 **Ziziphi ezinye iilwimi onako ukuzithetha?**
What other languages can you speak?

IsiXhosa	**Isingesi**	**Isisotho**	**IsiZulu**	**IAfrikanisi**	**Olunye**
Xhosa	English	Sotho	Zulu	Afrikaans	Other
☐	☐	☐	☐	☐	☐

Q.9 **Wenzani ukuziphilisa ebomini?**
What do you do for a living?

Ndiyasebenza ☐ I am working
Ndiyafunda ☐ I am studying
Andisebenzi ☐ I am unemployed
Andifundi ☐ Not studying

Q.10 **Ukuba uyasebenza / uqashiwe usebenza umsebenzi onjani?**
If you are doing a formal job, what is it?

.....

Q.11 **Ukuba kukho umsebenzi ozenzela wona ukuzingenisela imali yintoni oyenzayo?**
If you are doing informal work, what do you do?

.....

Q.12 **Ungayichaza kanjani imeko yenu yokuphila?**
How would you describe your economic condition?

TICK ONE OF THE FOLLOWING CATEGORIES:

Ndiyasokola Struggling	**Ndiyakwazi ukuphila** Doing okay	**Ndime kakuhle** Well off
☐	☐	☐

Q.13 **Ungazibiza ngokuba ulikholwa/ ungumKristu?**
Would you call yourself a Christian?

.....

Q.14 **Ukuba ungumKristu ukhonza kweyiphi inkonzo?**
If you are a Christian in which church?

.....

Q.15 **Luhlobo luni lweCawa/Nkonzo?**
What kind of Church is it?

African Indegenous Zionist	**African Indegenous Ethiopian**	**African Idegenous Other**	**Charismatic Pentecostal**
☐	☐	☐	☐

Evangelical	**Mission origin e.g Meth, Presby, Congr., Lutheran, Anglic, Dutch, etc.**	**Roman Catholic**	**Other**
☐	☐	☐	☐

SICELA UKUBA UZALISE EZINKCUKACHA ZILANDELAYO NANGOKUMAKISHA KWIBHOKISI EFANELEKILEYO
PLEASE FILL IN BY MARKING ON THE RELEVANT BOX

Q.16 **Xa ungaphilanga zizifo ezixhalabisayo ezinje ngesifo sephepha (TB). umhlaza, Izintso, inyumoniya, uGawulayo (HIV/AIDS), isifo sentliziyo, isibindi, ukukruneka nokudumba konyawo/umlenze nezinye nezinye usebenzisa awaphi/oluphi uhlobo lokunyanga?**
When you are not well with serious physiological illnesses such as TB, Cancer, HIV/AIDS, Kidneys, Liver, Pneumonia, Hearth disease, swollen leg, or any other, which of the following healing strategies do you adopt?

TICK ONE OR MORE OF THE FOLLOWING CATEGORIES:
KHETHA IBENYE OR NGAPHEZULU KWEZI ZILANDELAYO:

Uqgirha/unyango lwesilungu	**Igqirha/Unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.17 **Xa ungaphilanga zizifo eziqhelekileyo ezinje umkhuhlane oqhelekileyo, ukhohlokhohlo ingqele, intloko, nezinye nezinye usebenzisa awaphi/oluphi uhlobo lokunyanga?**
When you are not well with mild illnesses like common cold, fever, headache, or any other which of the following healing strategies do you adopt?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.18 **Xa ungaphilanga zizifo ezinxulumene nengqondo, ezinje ngamafufunyana, ukuphazamiseka engqondweni, nezinye nezinye usebenzisa awaphi/oluphi uhlobo lokunyanga?**
When you are not well with psychic illnesses like spirit possession, mental disturbances or any other, which of the following healing strategies do you adopt?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Andizange ndibe kule meko ☐
Never been in this situation

Q.19 **Xa ungaphilanga zizifo eziphazamisayo ezinje ngesitresi/uxinzelelo lwemithambo, ukudinwa nokuphazamiseka emphefumlweni, amaphupha amabi, nezinye nezinye, usebenzisa awaphi/oluphi uhlobo lokunyanga?**
When you are not well with psychological illnesses like anxiety, stress or any other, which of the following healing strategies do you adopt?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.20 **Xa elinye lamalungu oSapho lwakho lingaphilanga zizifo ezixhalabisayo ezinje ngesifo sephepha (TB). umhlaza, Izintso, inyumoniya, uGawulayo (HIV/AIDS), isifo sentliziyo, isibindi, ukukruneka nokudumba konyawo/umlenze nezinye nezinye, ngawaphi/loluphi uhlobo lokunyanga kula alandelayo onokumkhuthaza ukuba asebenzise lona/wona?**
When a member of your family is not well with serious physiological illnesses such as TB, Cancer, HIV/AIDS, Kidneys, Liver, Pneumonia, Hearth disease, swollen leg or any other, which of the following healing strategies would you encourage them to use?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.21 **Xa elinye lamalungu oSapho lwakho lingaphilanga zizifo eziqhelekileyo ezinje ngefever eqhelekileyo, ukhohlokhohlo ingqele, intloko, nezinye nezinye ngawaphi/loluphi uhlobo lokunyanga kula alandelayo onokumkhuthaza ukuba asebenzise lona/wona?**
When a member of your family is not well with mild illnesses like common cold, fever, headache, or any other, which of the following healing strategies would you encourage them to use?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.22 **Xa elinye lamalungu oSapho lwakho lingaphilanga zizifo ezinxulumene nengqondo ezinje ngamafufunyana, ukuphazamiseka engqondweni, nezinye nezinye ngawaphi/loluphi uhlobo lokunyanga onokumkhuthaza ukuba asebenzise lona/wona?**
When a member of your family is not well with psychic illnesses like amafufunyana (spirit possession), mental disturbances or any other which of the following healing strategies would you encourage them to use?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Q.23 **Xa elinye la malungu oSapho lwakho lingaphilanga zizifo eziphazamisayo ezinje ngesitresi/uxinzelelo lwemithambo, ukudinwa nokuphazamiseka emphefumlweni, nezinye nezinye ngawaphi/loluphi uhlobo lokunyanga onokumkhuthaza ukuba asebenzise lona?**
When a member of your family is not well with psychological illnesses like anxiety, stress or any other which of the following healing strategies would you encourage them to use?

Uqgirha/unyango lwesilungu	**Igqirha/unyango lwesintu**	**Abathandazeli**
Western scientific medicine	Traditional healing	Faith healing
☐	☐	☐

Andizange ndibe kule meko
Never been in this situation ☐

Q.24 **Apho usebenzisa iindlela zokuphilisa ezimbini nangaphezulu ngaxeshanye kuxa kutheni?**
Where you say you are using two or more healing strategies (mixing) could you tell me why?

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Q.25 **Ukuba uyaxuba, usebenzisa iindlela zokuphilisa ezimbini nangaphezulu uzisebenzisa njani?**
If you are mixing how do you mix?

☐ **Ndizisebenzisa yaye ndizithatha ngokulinganayo ndizisebenzisa ngaxeshanye?**
I treat them equally

☐ **Ndiya kwenye kuqala xa ingasebenzi ndiye kwenye ndiluyeke oluya lokuqala uncedo?**
I go to one first and if it does not work I try the other one?

Q.26 **Ukuba uyazixuba uzisebenzisa indlela ezimbini nangaphezulu uqala ulufune phi uncedo lokuphilisa amaxesha amaninzi, kutheni?**
If you are mixing or using more that one healing method, where do you usually go first to seek help and why?

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Q.27 **Kumava akho ngokugula ucinga ukuba kuluncedo ukuxuba ezindlela zokunyanga/zokuphilisa.**
In your illness experience do you think it is helpful to mix health-healing systems?

Kuluncedo	**Akuloncedo**	**Kuxhomekeka kwisigulo eso**
Helpful	Not helpful	It depends on one's sickness
☐	☐	☐

Q.28 **Apho uthe wasebenzisa iindlela ezimbini nangaphezulu ingaba wancedeka?**
Where you have mixed has it helped you?

Ewe qho Yes always ☐ **Hayi qho** No always ☐ **Ngamanye amaxesha** Sometimes ☐

Q.29 **Ukuba awuxubi unazizathu zini?**
If you are don't mixing what are your reasons?

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