

3

**The indigenous knowledge and attitudes
of older persons living in Khayelitsha
and Phillipi regarding the management
of minor health ailments.**

Mbuyiseli Simon Zonke

**Submitted in fulfillment of the requirements of the degree of M Sc (Med) at
University of Cape Town**

Supervisor: Ms G. Mji

Co-supervisor: Mrs J. Keikelame

JUNE 2005

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

DECLARATION

I, the undersigned, hereby declare that the work contained in this research thesis is my own original work, that I have not previously submitted it in its entirety or in part to any other university for a degree or examination in any university, other quoted material has been indicated and acknowledged by complete references.

Signature..... Signed by candidate
Signature Removed

Date..... 15/06/05.....

ACKNOWLEDGEMENTS

The author wishes to thank the following people for their time, advice, support and encouragement during the course of the study.

Ms Gubela Mji: For her supervision, guidance and brilliant insight throughout the course of the study.

Dr Hugo: For his guidance and theoretical input on research methods.

Mrs Nokhanyiso Zonke (Wife): For her support, courage and consistent motivation throughout the period of the study.

Mrs Nolusapho Zonke (Mother): For keeping me in her prayers all the time and supported the study throughout.

Messrs Mzamo, Daliwonga and Mongezi; Ms Thobeka Zonke (Siblings): For their consistent support.

Sandiso, Uyathandwa and Ovayo (My daughters): For their support and patience.

Mrs Nondwe Mlenzana (Colleague): For her support and encouragement.

National Research Foundation: For financial support.

Community Health Service Organization: For allowing me to pursue this study.

Senior Citizen Centers: For the managers of these centre who allowed me to utilize their centers for the study.

Makhulus and tatomkhulus: For their willingness to share their experiences and indigenous knowledge.

ABSTRACT

Khayelitsha (Site B), Michael Mapongwana, Inzame Zabantu and Mzamomhle community health centres in Khayelitsha and Phillipi are overcrowded and overburden with clients. Some of the clients attending these community health centres (CHC's) present with minor health ailments. As a result of overburdening, health care professionals are unable to deal properly with more serious ailments and health education. It is assumed that there is lack of knowledge related to management of minor health ailments in the home situation.

This problem of overcrowding of CHC's with clients presenting with minor health ailments was discussed in the community health forums that constituted of health managers from the above mentioned community health centres, clinical facilitators from University of Cape Town, students and older people. In these discussions, it was assumed that due to migration and urbanization, there has been a breakdown in traditional family units whereby in households of clients presenting with minor health ailments, there might be a lack of support from older people.

Older people had perceptions that minor health ailments can be contained within the home situation using the indigenous health knowledge carried by them. This knowledge is carried by word of mouth from generation to generation. Nothing has been documented about this knowledge. Ideas were discussed on how minor health ailments could be managed within the home situation and how a relationship could develop between older people and the health professionals in the CHC's that are overcrowded.

The community health forum concluded that the first step of dealing with the overcrowding of the community health centres, would be to explore the indigenous health knowledge that is carried by the older people for the management of minor health ailments.

A descriptive study was conducted using qualitative and quantitative methods of data collection. Four focus groups with nine participants in each were conducted using an interview schedule. The data was analysed quantitatively and qualitatively to gain understanding of indigenous health knowledge used by older people living in Khayelitsha and Phillipi.

Results of the study showed that older people had an extensive knowledge related to management of minor health ailments. According to the participants, there was no distinction between minor and major ailments, all ailments could be managed within the home situation using indigenous health knowledge. The management strategies that were used by older people were in different forms namely, plants, objects, waste products, artificial foods, other natural resources and belief system. Older people mentioned that their comprehensive approach of managing any ailments resulted from a scarcity of nearby health resource.

In the present climate in Khayelitsha and Phillipi where CHC's are overcrowded with clients presenting with minor health ailments and exhausting the present health resources, one could envisage a future whereby indigenous health knowledge could be integrated in the present health dispensation for the management of minor health ailments. Hence the researcher is making recommendations to the management of community health centres to start initiating discussions on how indigenous health knowledge could be integrated into the present health system of community health centres in Khayelitsha and Phillipi.

DEFINITION OF TERMS

Client

The client is a person who is in control of him/herself at his/her home or in the community but dependant on health professionals for health care. Health is the only aspect of life where the client is dependant, all his/her other aspect is in his/ her own control (Armentrout, 1998).

Community Health Centre

A community health centre is a centre that is responsible for rendering and co-ordination of primary health services to a defined community and its satellite clinics and outreach programmes, and community service including those of an environmental office and community health workers (Western Cape Province Ministry of Health and Social service strategic management team, Draft 4, 1996).

Indigenous Knowledge System

The knowledge, technologies and community indigenous to a particular geographic area (National Research Foundation, 2001). Relating to this the study, it is health knowledge (remedies and treatments) carried by older persons in Khayelitsha and Phillipi. Hence the term indigenous health knowledge will be used by the researcher to describe the health knowledge used by older people in the care of minor health ailments.

Local Authority

An administrative structure managed by a group of councillors. Local authorities Provide a wide range of services including water, sewerage, electricity, transport, libraries, parks, sports-grounds, housing and health (Reddy, 1996).

Makhulu

“Makhulu” means grandmother, who is a female, older person who progressively does less work at the home and in the fields. Instead she directs the work to her children and her sons’ wives and grandchildren. She has the right to control the work of all the women in the household and is responsible for the progress of the younger women. She has the big say in the affairs of the household and the younger generation listens to her. In her old age her family will care her for (Merteerns & Gray, 1973).

Minor health ailment

Common aches and pains that can be treated at home without the need for prescribed medicine, e.g. colds, minor cuts, diarrhoea, stomach aches, nose bleed, insect bites and rash (www.demon.co.uk/ailments.htm2001/05/11).

Older Person

Is defined as a person who has experience about life and can approach daily problems using previous experience (Mtyapi, 2001). According to the human Developmental stages, older person ranges from 55-75years (Froggat, 1990). In a Xhosa context and relative to this study, an older person is a grandmother/grandfather who has years of experience in the management of illnesses at home using available resources and their ages commonly are in the above-mentioned range.

Primary Health Care

A client's first point of entry into a comprehensive community health care system.

Primary health care is the first element of a continuing health care process (Denhill, King and Swanepoel, 1999).

Tatomkhulu

“Tatomkhulu” means grandfather who has achieved the status of an older person in his community. He progressively does less hard work, only directing the efforts of his children. He has the right to supervise others and is listened to with respect by all in the community. In his old age, the young members of his family will look after him (Merteerns & Gray, 1973).

Unconventional medicine

Refers to medical practices that are not in conformity with the standards of the medical community. Examples of these comprise of acupuncture, chiropractice, massage therapy and home-base medication. Unconventional medicine in this study will be interchangeably used with other terms such as alternative medicine, traditional medicine unorthodox medicine, home-based remedies, and natural herbs (Eisenberg, Ronald and Kessler, 1993).

LIST OF ACRONYMS

Acronyms used by the Provincial Administration of the Western Cape and Non-Governmental Organizations.

CHC:	Community Health Centre
CHSO:	Community Health Service Organization
FHS:	Faculty of Health Sciences
IHKS:	Indigenous Health Knowledge System
NOAH:	Neighbourhood Old Age Home
NRF:	National Research Foundation
PHC:	Primary Health Care
SACLA:	South African Christian League Association
UCT:	University of Cape Town
UWC:	University of the Western Cape
WHO:	World Health Organization
ANC:	African National Congress

University of Cape Town

TABLE OF CONTENTS

CHAPTER 1: BACKGROUND OF THE STUDY

1.1 Problem identification	1
1.2 Evolution of the problem	1
1.3 Motivation of the study	5
1.4 Significance of the study	7
1.5 Summary of chapter 1	9

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction	10
2.2 African indigenous health belief models	13
2.3 African approach to health in the home setting	15
2.4 Migration and urbanisation of older people	17
2.5 Perspective of the current health system	19
2.5.1 The era of colonizers and missionaries	20
2.5.2 The birth of Primary Health Care	20
2.5.2.1 International perspective of Primary Health Care	20
2.5.2.2 National perspective of Primary Health Care	21
2.5.2.3 Implementation of Primary Health Care in the Western Cape	22
2.5.3 Problems with the implementation of Primary health care in South Africa	23
2.5.4 Some success stories about PHC in South Africa	25
2.6 List of minor ailments according to Western medicine	26
2.7 Summary of chapter 2	29

CHAPTER 3: METHODOLOGY

3.1	Aim of the study	31
3.2	Objectives of the study	31
3.3	Study design	31
3.4	Study setting	32
3.5	Study population	34
3.6	Study sample and sampling methods	34
3.7	Eligibility criteria	35
3.7.1	Inclusion criteria	35
3.7.2	Exclusion criteria	35
3.8	Instrumentation	35
3.8.1	Method of data collection	35
3.8.1.1	Advantages of focus group interview	36
3.8.1.2	Disadvantages of focus group interview	36
3.9	Procedure	37
3.9.1	Pilot study	37
3.9.2	Implementation	37
3.10	Data analysis	39
3.10.1	Qualitatively analysis	39
3.10.2	Quantitatively analysis	39
3.11	Validity, Reliability and Bias	40

CHAPTER 4: PRESENTATION OF RESULTS AND DISCUSSIONS

4.1	Objective 1: To describe the study setting and also to determine the demographic details of the sample.	41
4.1.1	Demographic details of the sample	41
4.1.2	Demographic details of participants.	43
4.1.3	Discussion of objective 1	44
4.2	Objective 2: To determine what older person regarded as minor health ailments.	45
4.2.1	To determine what older people mentioned as minor health ailments.	45
4.2.2	Discussion of objective 2	52
4.3	Objective 3: To determine what and how home-based medicine is used in the management of each of these minor illnesses?	53
4.3.1	Data collected from the four senior citizen centre in respect of the management of minor health ailments by older people.	53
4.3.2	Discussion of objective 3	81
4.4	Objective 4: To determine when the older people would regard that their strategies are not working and who would they refer to.	82
4.4.1	Discussion of objective 4	83
4.5	Comments	84
4.6.	Limitation	85
4.7	Validity	85
4.8	Summary of Chapter 4	86

CHAPTER 5: SUMMARY OF THE STUDY AND RECOMMENDATIONS	87
REFERENCES	91
APPENDICES	
1 Permission Requisition Letter	95
2 Consent form : English version	96
3 Consent form : Xhosa Version	97
4 Interview schedule: English version	98
5 Interview schedule: Xhosa version	99
6 Demographic information of senior citizen centres	100
7 Post-focus group questionnaire for the willing participants	101
8 Raw data from Masithandane senior citizen centre	102

LIST OF TABLES

Table 1	List of minor health ailments according to Western medicine.	27
Table 2	Description of different treatment approaches.	28
Table 3	Description of methods of administration.	29
Table 4	Demographic details of participants.	43
Table 5	List of minor health ailments mentioned by older people in each focus groups.	45
Table 6	Common minor health ailments in all focus groups.	48
Table 7	Health ailments that could be considered as major ailments.	49
Table 8	Other health ailments that were consider neither minor nor major by the researcher.	50
Table 9	Home remedies that were used by older people of Noxolo senior citizen centre and method of administration of those remedies.	54
Table 10	Home remedies that were used by older people of Masiphumelele senior citizen centre and method of administration of those remedies.	57
Table 11	Home remedies that were used by older people of Mzamomhle senior citizen centre and method of administration of those remedies.	63
Table 12	Home remedies that were used by older people of Masithandane senior citizen centre and method of administration of those remedies.	67
Table 13	Treatment approaches and methods of administration of Noxolo senior citizen centre.	69
Table 14	Treatment approaches and methods of administration of Masiphumelele senior citizen centre.	71
Table 15	Treatment approaches and methods of administration of Mzamomhle senior citizen centre.	76
Table 16	Treatment approaches and methods of administration of Masithandane senior citizen centre.	79
Table 17	Referral sources of older people when their strategies failed.	83

CHAPTER 1

BACKGROUND OF THE STUDY

1.1 Problem identification

Khayelitsha (Site B), Michael Mapongwana, Inzame Zabantu and Mzamomhle community health centers (see definition of terms in pg v) in Khayelitsha and Phillipi are overburdened with clients (see definition of terms in pg v). Some of the clients attending these community health centers (CHC's) present with minor health ailments (Keeran, Naidoo, Parker & Royker, 2000). As a result of overburdening, health care professionals are unable to deal properly with more serious ailments and health education. It appears that there is lack of knowledge for management of minor health ailments at home and that indigenous health knowledge carried by the older people has not been acknowledged by the younger generation in these communities. There is also a belief that Western medicine is more effective than the traditional or indigenous health knowledge.

1.2 Evolution of the problem

The Khayelitsha and Phillipi communities are predominantly black townships situated on the Cape Flats. These communities are approximately 26 km and 20 km from the center of Cape Town, respectively. Most people living in these communities experience social problems such as poverty, unemployment, overcrowding, and crime. Khayelitsha has an approximate population of 1000 000 people whereas Phillipi has approximately 500 000 people (Statistics South Africa, 1996).

Housing in these communities varies; there are houses that are small, individually constructed using mortar (Municipal housing scheme) while others are informal settlements popularly known as shacks. There are also subsidized houses that are within these communities, mostly afforded by employed and business people.

Most people who reside in Khayelitsha and Phillipi communities have relocated from the Eastern Cape in order to seek employment opportunities in Cape Town. When they arrive from the Eastern Cape, they would first stay in the backyard of government municipal

houses. Some of them would end up staying permanently in shacks or in the backyards of government municipal houses. Amongst people who are residing in Khayelitsha and Phillipi, there are also older people who have relocated to Cape Town to seek health services and ended up staying in these communities. Relocation from rural to urban areas has completely changed the lifestyle of the people that reside in these areas. Health issues are one of many activities that have changed for the people who live in these communities. People who live in Khayelitsha and Phillipi predominantly utilize state hospitals and clinics for their health problems instead of managing them within the home environment like the olden days.

Health delivery in the Western Cape Province (South Africa) including areas such as Khayelitsha and Phillipi are delivered through the district health system. The Provincial health Administration of the Western Cape developed a district health plan in 1996 in which Khayelitsha is known as District 7 and Phillipi as part of District 3. Khayelitsha has three community health centres: Khayelitsha CHC (24 hour facility) situated at Site B; Michael Mapongwana CHC (day facility) situated at Harare; and Nolungile CHC (Day facility) situated at Site C. Phillipi has two community health centres, Inzame Zabantu and Mzamomhle that operate as day facility. These two community health centres have different management structures; Inzame Zabantu falls under the Local Authority (see definition of terms in pg v) while Mzamomhle falls under Provincial Administration of the Western Cape.

The Faculty of Health Science (FHS) of the University of Cape Town (UCT) has adopted the Primary Health Care approach as the basis for its curriculum construction and is involved in the above-mentioned CHC's. Different groups of undergraduate students from the Schools of Public Health and Primary Care, Rehabilitation Sciences as well as students from other faculties, and two other universities in the Western Cape spend a period of approximately 5 weeks as part of their clinical training in Khayelitsha and Phillipi.

The Ottawa Charter in 1986 identified three main focus areas for Primary Health Care delivery and for health promotion: advocacy, enablement and mediation (Coulson, Goldstein & Ntuli, 1986). These are the major focus areas for UCT students working in these CHC's. It was whilst UCT students were conducting health promotion classes in

Khayelitsha and Phillipi that they noticed that the CHC's were always overcrowded with clients. They questioned why the CHC's are overcrowded and undertook a mini epidemiological descriptive study. Students' epidemiological projects showed that the majority of clients who visit the Community Health Centres were between the ages of 20 and 49 years (Brice, MacGurk, Petkar & Phillip, 2000). This study revealed that during the period of May to June 2000, 24-33 % of these clients daily presented with minor health ailments (Brice *et al*, 2000).

According to the Alma Atta Declaration, the aim of the Community Health Center and Primary Health Care is to make health care accessible to the respective community (Fry & Hasler, 1986). When the CHC's are overcrowded, it is questionable if they are still accessible to the community. The students saw this as a problem and assumed that clients with more serious health ailments were not getting enough time for the management of their conditions. The students further questioned why these clients were presenting with minor health ailments and why they were not managing their ailments at home. Did they know anything about home-based remedies?

In an attempt to answer the above questions students decided to discuss the problem of overcrowding by clients with minor health ailments with the CHC's health professionals and community representatives, including the makhulu and matomkhulus (grandmothers and grandfathers respectively). Furthermore, questions arose from these discussions about who usually assists with the management of minor health ailments at home. The concept of an illiterate society (especially in rural areas), is that people used to manage any form of illness at home using home remedies and in these societies older people used to play a pivotal role. The older people, especially the grandmothers, believed that overcrowding of CHC's with clients presenting with minor ailments could be reduced by integration of indigenous health knowledge to the present health system.

The debate regarding the overcrowding of clients presenting with minor health ailments continued to be discussed at the community health forum. It became apparent that the older people who were mainly grandmothers and grandfathers (makhulu and tatomkhulu) were the people who assisted when one of the family members presented with minor health ailments in the home. From these community health forums, it was also concluded that awareness could be raised about the value of the indigenous health knowledge and a

partnership that could develop between CHC's and the communities, whereby older people could play a pivotal role, as they were the first line practitioners in the home environment.

From these discussions, a core group called the Makhulu and Tatomkhulu Project was formed, that included older persons from Khayelitsha and Phillipi, health workers from Khayelitsha, Michael Mapongwana, Inzame Zabantu and Mzamomhle CHC's, students and clinical facilitators from the UCT Schools of Public Health and Primary Care and Rehabilitation Sciences and community representatives. The community health centers that are part of this study have been chosen because there are UCT students doing their clinical training in these CHC's. Furthermore all the students in these centers have identified the same problem of the CHC's being overcrowded with clients who presented with minor health ailments.

The main aims of this core group were:

- To investigate why the clients come to the community health center with minor health ailments instead of managing them at home.
- Explore the indigenous health knowledge carried by the older persons in the care of minor health ailments.
- Explore if introducing the indigenous health knowledge carried by the older people could alter the health seeking behaviors of clients presenting with minor health ailments.

Funding was obtained by this group from the National Research Foundation (NRF) of which two Masters' students were funded to explore the above- mentioned topics. The researcher is one of Masters' students that are funded by NRF and his responsibility is to determine the indigenous knowledge carried by the older person in management of minor health ailments.

1.3 Motivation for the study

“... the medicinal use of herbs is said to be as old as mankind itself...”
(Kubukeli, 1999).

South African black people always had natural survival strategies in approach to life (Mtyapi, 2001). In the olden days, black people used to manage minor health ailments through optimal utilization of available resources within the environment. Older people, mostly grandmothers, use to play key role in the management of ailments in a home environment. They use to pass their wisdom to their children. The changing times had both negative and positive impact in the above-mentioned practices. In the course of establishing and developing themselves, older people migrated to big cities for various reasons, and this resulted in a lot of changes in their lives. Their lifestyle has changed completely because of adjustment to urban settings. Existence of hospitals, private doctors, clinics and other modern practices have been convenient to the people whilst simultaneously they have disturbed their ways and means of managing health issues (Mtyapi, 2001). This has not happen in isolation, like socio-political factors and other issues have contributed to the sudden change of lifestyle.

In 1994, South Africa became a democratic country and the government of the day chose Primary Health Care as a way of health care delivery for the country. Primary Health Care services were implemented in 1996, and this was done to ensure accessibility of health services to the people in the South African communities, as well as addressing health inequities in South Africa. This was further supported by the proliferation of clinics and community health centres. Despite this, Community Health Centres continue to be overcrowded with people presenting with different ailments.

Although in 1994 as mentioned above Primary Health Care was implemented by the democratically elected government to improve access to health care especially to disadvantaged communities such as Khayelitsha and Phillipi, access to comprehensive health care keeps eluding the South African communities. The very community health

centres that were implemented to improve access, are plagued with problems. The type of problems experienced in these community health centres is characterized by:

- Overcrowded environments with long queues
- Long waiting times at the clinics.
- Brief encounters with doctors or hospital staff, often less than 5 minutes.
- Feeling of confusion and being alone in an unaccustomed environment.
- No opportunity to express one's own concerns.
- Being given medicine without any explanation as to the cause of the illness and without proper explanation of the effects of drugs (Gessler, Msuya & Nkuya, 1995).

Burhman (1983) maintains that the concept of "community involvement" implies that it is not only the responsibility of external agencies and specialist trained health practitioners and the family physician, but also a responsibility of the whole community to ensure that the health of every member should be maintained at its optimum level. They continue to argue that the health in many proliferate societies depends on the survival of the group through the ability of each individual to fulfil his role, and the knowledge of healing being passed from generation to generation (Mtyaphi, 2001; Van Wyk, Van Oudtshoorn & Gericke, 1997).

Gessler *et al*, (1995) maintain that in rural areas, alternative medicine may be the only available source of health care within reasonable distance. Indigenous knowledge is an important part of South Africa's cultural heritage. Before the development of synthetic chemicals, plants were one of the main sources of ingredients for medicine and they were also a source of food and material for equipment. It is when the European countries colonized the African continent that this knowledge became a secret.

Furthermore, South Africa cannot afford a Euro-centric medical approach only (Sunday Times Lifestyle, 1999). South Africa needs to explore its own resources that are affordable and reliable for its inhabitants. People of this country need to revisit the utilization of natural plants for management of health problems, because it is affordable especially to the South African citizens who are mostly unemployed.

Presently, there is an assumption that in South Africa, health changes has affected the status of indigenous knowledge including the acknowledgement of home-based remedies. Hospitals were unfamiliar places to the black community (Gumede, 1990). People used to

manage ailments at home with remedies provided by older persons when they were sick. In the home situation, taking somebody to a traditional healer would be a form of referral system when home remedies had failed. Primary Health Care is about acknowledgement of resources that are available within the community. It is important to recognize that the first treatment of a health related ailment happens at home.

In recent years, traditional healers are getting more recognition and are collaborating with medical practitioners in managing primary health service (Medical Research Council, 1997). However, there has been no acknowledgement of the older people (Makhulus and the Tatomkhulus) about the role that they have played in the care of minor health ailments within the home situation.

1.4 Significance of the study

There is very little work that has been done exploring the influence of indigenous health knowledge that the older people hold in complimenting the modern day health system in curbing minor health ailments. A study that was similar to the current study was done in Kenya (Green Africa Network, 1993). The aim of the research was the preservation of the indigenous health knowledge of local herbalist and to audit and develop a database of their materials and methods that would be captured for coming generations. In South Africa there is no study that has explored the role of the older people in the care of minor health ailments hence this study will assist in determining which home based medicines and remedies are used in the care of minor health illnesses. In African society the pioneers of that knowledge are older people and also they are the ones that facilitate health issues in home environment. The researcher will also explore the effectiveness of these home based medicine used by older persons, and document the data related to management of minor health ailments.

This study might also assist in influencing Primary Health Care policies in terms of understanding indigenous methods of managing minor health ailments. Furthermore, it will contribute towards trying to reconcile the conventional and unconventional medicine. It is hoped that these policies may acknowledge the strategies used by older people in the management of minor ailments at home.

This study may also help in developing interpersonal relationship between community health centers and communities through sharing methods of managing health issues at home as well as in hospital setting. It is hoped that the deliberations between the above mentioned stakeholders may simultaneously decrease the overcrowding that is currently prevailing at CHC's by introducing first line of treatment in home situation and encouraging utilization of available resources and considering safety precautionary measures during the use of these measures.

The study is hoping to influence the undergraduate and postgraduate student training in a Primary Health Care led curriculum by including consideration of available resources in the communities and also the importance of involving the community in the development of health related issues. This might help the young professionals broaden their knowledge about community issues and also develop a platform of mutual learning about the value of teamwork in health delivery. Furthermore, it may also improve interdisciplinary collaboration not only between departments in the health science, but also with other faculties in UCT such as links with African studies. It is hoped that the outcome of the study in Khayelitsha and Phillipi may open opportunities for other faculties that serve as arenas where related academic research on issues regarding older people can be conducted in future. The current study may add to the collection of studies on indigenous health care knowledge in academic circles.

It is also hoped that this study might influence policy makers to re-evaluate the value of indigenous knowledge especially within the Primary Health Care approach. Indigenous knowledge, together with its carriers (older people) had played an important role in health care management whilst there was no western medicine to address health issues. It would require the policy makers to understand and acknowledge indigenous knowledge and give it an opportunity to develop and later to reconcile and integrate with the current health system. It is also envisaged that further research would need to be done to assess the impact of integrating (imparting) indigenous knowledge of older people in the care of minor ailments. Therefore this study hopes to use the information gleaned to advocate the use of home remedies to treat minor health ailments. The Department of Health might see the opportunity to initiate effective cross-cultural and affordable Primary Health Care services.

The study might also recognize the important role that can still be played by older person in our society in health promotion through introducing alternative means of managing health problems and educating the younger generation about alternative ways of managing health problems in the home, using the wisdom of the older people. The researcher aims to share this project in both national and international conferences with other Primary Health Care researchers.

1.5 Summary of Chapter 1

In 1994 the African National Congress lead government implemented Primary Health Care in all communities in order to make health accessible to people residing in the respective community. This has not solved the problem completely in Khayelitsha and Phillipi CHC's as the CHC's in these areas are still overburden with clients presenting with minor health ailments on a daily basis. Questions were asked in health forums regarding overcrowding and solutions were sought to the problems. Older people had perception that this problem could be managed by exploring and reviving indigenous knowledge related to health carried by them. The researcher is acknowledging these perceptions by conducting this study. This study is the first step being taken to decrease overcrowding of CHC's in the study areas.

In the next chapters, the researcher will discuss the literature relevant to the study in chapter 2; discuss the methodology that the researcher used in chapter 3; present the results and discussion of each objective in chapter 4; summarize the study and make recommendations and conclusion in chapter 5.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The aim of the study is to explore the indigenous health knowledge carried by older people in the management of the minor health ailments in Khayelitsha and Phillipi communities. This study evolved due to the problem of overcrowding of Community Health Centres (CHC's) with clients that present with minor health ailments at Khayelitsha and Phillipi community health centres (Keeran *et al*, 2000). According to the Alma Atta Declaration, the aim of the Community Health Centre and Primary Health Care is to make health care accessible to the respective community (Fry & Hasler, 1986; Denhill, King, & Swanepoel, 1999; Department of Health, 2001).

In 1994, South Africa became a democratic country and the African National Congress (ANC) government chose Primary Health Care as a way of health care delivery for the country (Denhill *et al*, 1995). Primary Health Care services were implemented in 1996, and this was done to ensure accessibility of health services to disadvantaged people of South Africa. Furthermore this was supported by the proliferation of clinics and community health centres (Department of Health, 2001). Despite this, Primary Health Care had been plagued by many problems such as quality of health care, shortage of staff and overcrowding. This raises some questions such as: Is Primary Health Care still reaching its primary objectives such as improving access to health to disadvantage communities such as Khayelitsha and Phillipi? How was the Primary health care implemented in both these communities? Did Primary Health Care consider the resources that are available within these communities, or did it only focus on the modern medicine (Jeebhay, Hussey & Reynolds, 1997)?

Having observed this problem of overcrowding in Khayelitsha and Phillipi steps were taken by University of Cape Town (UCT) health science students, health authorities and health workers to involve both Khayelitsha and Phillipi communities and service providers including older people from these communities to try and find solutions to the problem of overcrowding. From the older people's perspectives, community resources

have older people who use to be first line managers of health problems in a home environment, herbalists who assist with medicinal plants that help ill people, diviners who have cultural methods and strategies of dealing with illnesses. Hence this study was undertaken as an acknowledgement of the importance of community involvement in Primary Health Care service delivery (Gessler *et al*, 1995; Buhrmann, 1983). Simultaneously, the study may assist in the development of relationships between conventional and non-conventional medicine and improve cooperation between communities and health service providers (Buhrmann, 1983).

According to Guma (2004), indigenous knowledge is the knowledge that is held and used by people who identify themselves as indigenous of a place based on a combination of cultural distinctiveness and prior territorial occupancy. This means that the indigenous nature of people is determined by the place where they stay as well as their cultural belief system. Liddel, Barret & Bydowell (2004) maintain that beliefs about disease form part of a culture's indigenous knowledge system (IKS). An IKS represents a culture's collective body of accumulated knowledge and wisdom, evolved through successive generations of experience and trial- and- error (Liddell, Barret & Bydowell, 2004). Hence older people with their wisdom and accumulated knowledge felt that they could make a difference with the current problem of overcrowding CHC's at Khayelitsha and Phillipi communities.

In traditional societies such as African ethnic groupings such as Xhosas, older people remain the dominant member and important member of the family as well as the extended family. Even when children grow and assume the status of being breadwinner, older people suffer no loss of status and their role is clearly defined (De Haan, 1996). Both communities (Khayelitsha and Phillipi) are predominantly black communities. Although older people still believe that they can still play the status role of being health carers of their families, it is assumed that older people, who reside in these communities, have lost their status of the being so-called home health specialist and also the opportunity of practising their indigenous knowledge for health problems. According to Mtyaphi (2001) older people once had valuable status in black community, such as health advisors, household managers, and also doing general activities at each home setting. Ever since they relocated from rural to urban communities, they have lost some of the roles that they

assumed in the rural areas. But these roles have changed with changing lifestyle, migration from rural to urban settings and other family dynamics.

After having changed their lifestyle and relocated to peri-urban areas, the researcher wondered whether older people in both Khayelitsha and Phillipi have not lost status of being primary health carers. It is assumed and proposed by this study that they might still have the indigenous knowledge that they used to use before for health problems in their rural setting before migrating to townships such as Khayelitsha and Phillipi. The knowledge that older people retain was never given an opportunity to develop. Instead, it was marginalised (Guma, 2004) and it is currently disappearing as older people die daily due to ageing and other related problems. If this indigenous health knowledge could have been given a chance to develop, it could have been modified, adapted with changing times and refined in order to be parallel with modern medicine. The indigenous knowledge that older people have acquired is dynamic, adaptive and firmly rooted in the traditions of the past (Van Wyk *et al*, 1997; Guma, 2004). This knowledge is an oral-tradition medical system that was passed by word of mouth from one generation to the next (Mtyaphi, 2001). It is then further assumed and proposed that older people still hold indigenous knowledge related to the management of health related problems. What role can older people play as people who formerly provided health service back in rural settings? Hence it is necessary for the researcher to explore this indigenous knowledge, document it and make recommendations about proper utilization of this knowledge.

A study of this nature is the first of its kind in South Africa and the researcher found paucity in literature regarding this topic. Nevertheless, the researcher aims to explore issues such as African indigenous health beliefs models, the African approach in home setting, migration and urbanisation of older people, steps towards current health system, challenges facing Primary Health Care and list of minor health ailments according to Western medicine.

2.2 African indigenous health belief models

Health is defined as a complete state of physical and mental well-being (Denhill *et al*, 1995; Jeebhay *et al*, 1997). Traditionally, health is a combination of physical, mental as well as spiritual well being of a person (Kubukeli, 1999). According to Kubukeli (1999), older people in African society have a better understanding of sick people within their respective families. The health concepts within the framework of African culture are analyzed socially (behaviorally) more than biological (examination). Cultures all over the world and across the nations have evolved to illness representations that can accommodate not only new diseases, but also new epistemologies for explaining disease (Liddel, Barret, & Bydawell, 2004). Indigenous views of illness exhibit coherent structure, in which causation, prevention and treatment relate to one another in functional ways (Liddel *et al*, 2004). Even biomedical views of causation can be readily incorporated into traditional views of how illness is caused (Liddell *et al*, 2004).

According to Gumede (1990) social aspect has also influenced the health system in African communities. He mentioned that health problems were associated with factors such as ancestral punishment and sorcery. Ancestral punishment is perceived as survival of ancestors in the spirit world that depend on family lineage and accords regular attention from living offspring. This attention is manifested in rituals, sacrifice, and avoidance of high standards of social behaviour. Whenever these requirements are not met, illness can be sent as a warning or punishment (Liddell *et al*, 2004; West & Morris, 1976). Sorcery relates to people who have been offended by another person's behaviour and would inflict illness to that particular individual.

Even with these causal factors of illness, older people were still playing a key role in performing necessary rituals and sacrifice that will address the problem. Some people residing in both Khayelitsha and Phillipi communities still perform these rituals as a preventative measure. An example of this would be slaughtering a goat after death and burial of a person. This ritual is done to prevent an immediate death again in the family (Mtyaphi, 2001). This is one of the strategies that older people were using in maintaining a stable health system within their home setting. Health was maintained optimally at all times and most ailments were contained or managed within the home environment.

In the beginning, before the use of modern medicine, some black people believed that disease was attributed to a variety of spiritual or mechanical forces. It was interpreted as a punishment by God (popularly known as Qamata by older people) for sinful behaviour or the result of an imbalance in body elements (Spector, 1997). Older people used to prepare home remedies as means of managing disease available within a family setting. If the problem or disease continues to persist, older people would consult other family members or extended family. If there were a need to perform a necessary ritual, older people would facilitate the process and procedures. Sometimes older people were facilitating the process of healing by referring the sick person to a faith healer (Umthandazeli) who would manage the client further.

In certain situations, the efforts of older people failed and in such cases, they were forced to consult outside sources. Consultation of an outside source was used when the medical problem appeared to be beyond the scope of home remedies (Katz & Kimani, 1982). The outside sources that they would consult would be the traditional healers. This source is not a free service; it requires payment. Some traditional healers would state that if the medicine is not paid for, it would not work (Katz & Kimani, 1982). There are two different types of traditional healers: Igqirha (Diviner) and Ixhwele (Herbalist) and their roles are different (Visalli & Shepherd, 1999; Mtyaphi, 2001; Guma, 2004; Burhmann, 1983). The task of a diviner would be to restore good relationship between the living (sick person) and the dead (ancestors). People suffering from bad luck diseases would find out what the meaning of their ill misfortune was from the diviner (Visalli & Shepherd, 1999). The diviner would throw bones and determine the problem of the sick person. If the sick agree, the diviner would proceed with healing processes and procedures. The role of the herbalist would be to gather indigenous plants and make medicine from these plants for the sick person. The role of the herbalist would be to dispense medicine that would cure specific problems (West & Morris, 1976). Some people are currently using these models for health-related problems. Traditional healers' role is comprehensive and dynamic, sometimes they can be a priest, religious ritual specialist, family and community therapist, moral and social philosophers, teacher, visionaries, empirical scientists and perhaps political leaders in addition to being healers (Liddell *et al*, 2004). The traditional healers have endless roles in the society, which is more than just a referral source of older people, and their approaches are comprehensive. In countries like Nigeria, evidence

showed that people rely more on traditional healers for advice on illnesses (Liddell *et al*, 2004).

These African indigenous health belief models had both advantages and disadvantages. The advantages were the fact that these models promoted family cohesiveness (Mtyaphi, 2001). Whenever any person had health problem, it use to be a family's responsibility and not an individualistic problem. An example of this would be when a ritual was performed for a certain sick family member; everyone would actively participate in this activity. It also allowed family member to share their knowledge especially older people for instance they would remind each other on how their parents use to perform certain ritual. So it was a certain form of in-service training for family members to learn more about culture and treatment strategies used for certain health problems.

The disadvantages of these African indigenous health belief models were that some of these models were based on low moral values i.e. sorcery. Whenever any person is successful in life, jealousy would prevail among certain individual, as a result a bewitchment spell would be put on that particular person (Gumede, 1990). In certain cases there was just prejudice among family members with no justification and the end result would be mortality. Each family had always have means or approach to health in the home setting, but these will be discussed in the next component.

2.3 African approach to health in the home setting

In any African society, home is the heart of everything. It is where things start and it is where things end. This dates back as far as the Iron Age, when African people were using available resource in order to survive in life (Reader's Digest Association South Africa, 1988). Life was very simple then, natural plant resources were the main source of medicinal, cultural, religious and other needs (Mtyaphi, 2001; Bhat & Jacobs, 1995). In that period older people were playing an important role of maintaining stable health within the home setting.

People who were living in rural setting use to rely on cattle farming and natural vegetation for survival (Reader's Digest Association South Africa, 1988). People were using available resources in home setting for all health related problems. This practice was affected with changes that were happening within these African societies. Older

people were getting recognition and respect in their families (Mtyaphi, 2001). Their wisdom and respect was utilized effectively in all instances at home. Older people were rearing grand children, they used to cook food for their family, and they were determining who has to do household chores. Older people were managing health issues and determining the belief system of their families. Their role was endless and their value was important day by day in each family setting (Mtyaphi, 2001; Burhman, 1983). They maintained dignity and respect within their families.

Older people were very observant whenever there was a person in a family who was sick (Mtyapi, 2001). They were looking at the behavior of the person or child in a family. When older people noticed that a person is sick, first they examine, and then decide on the herbs that can be used and later prepare it (Bhat & Jacobs, 1995). They would do the action of preparing a mixture using available plants in order to help the sick person. Older people were patient when helping the sick person and they had a passion for what they were doing. Both grandmothers and grandfathers (Makhulu and Tatomkhulu) had a sense of responsibility and patience when they were maintaining stable health in their family. In countries like Cameroon, people utilize home remedies first when they encountered illness, then later consulted professional intervention (Jeebhay *et al*, 1997).

Most of the older people were illiterate, hence they never took the initiative of documenting their indigenous knowledge for future purposes (Mtyaphi, 2001). The indigenous knowledge that they retained in their minds has been used over and over all the years and it has been passed by word of mouth from generation to generations (Van Wyk, *et al*, 1997; Reader's Digest Association South Africa, 1988). The fact that this indigenous health knowledge has been used over and over the years, validated the knowledge that was retained by older people and also showed that their knowledge had been tested by time (Mtyaphi, 2001; Kubukeli, 1999).

A study was done in Kenya (Green Africa Network, 1993), which aimed at preserving the indigenous knowledge of local herbalists and developing a database of their material. The data collected for this study had been utilised effectively by people of Kenya who had experience health problems, especially those who were a far from health centres. The commonalities between the Kenya study and the current study are the exploration of indigenous knowledge and the development of a database. In addition to the current study

will explore this knowledge in addressing the problem of overcrowding C.H.C's at Khayelitsha and Phillipi with clients presenting with minor ailments (Keraan *et al*, 2000).

When all strategies that older people were using had failed in the management of minor health ailment at home, they consulted outside sources. Traditional healers were their referral source at that time because modern medical facilities were distant (Mtyaphi, 2001; Burhmann, 1983). They had confidence in traditional healers.

According Mtyaphi (2001), most people who utilised traditional facilities do so in recognition of the fact that traditional healing takes in to account that a person is not just a physical body but has a spiritual mind as well. Mackenna (1996) qualifies this statement by viewing alternative medicine as more patient-orientated and views the patient in much broader terms. Hence it is important for both Khayelitsha and Phillipi communities to explore the knowledge that older people retains, in order to utilize it effectively and to bring alternative methods to the health centers.

The prevalence of traditional healers in modern society is evidence in support of the persistence of indigenous beliefs about illness. A national professional council for traditional healers is currently in the path of getting recognition by government for their treatment methods (Cameron, 2005). According to the researcher, traditional healers are not only diviners and herbalist. It also includes older people who regularly use indigenous methods and strategies in health management. Ignoring indigenous knowledge carried by older people about illness, which African societies have long construed as essential for their survival and well-being, seems counterproductive to the development of culturally grounded and health prevention programs (Liddell *et al*, 2004).

2.4 Migration and urbanisation of older people

Modernization and urbanization had great impact on underutilization of indigenous knowledge systems as a tool for the management of health problems in South African black communities. People use to dwell in rural setting whereby there was limited stimulation in terms of technology and other modalities. Even now people who reside in rural areas of the former Transkei and Ciskei (now known as the Eastern Cape) depend on natural plant resources from forests for medicinal needs (Bhat & Jacobs, 1995). Gessler *et*

al (1995) maintain that in rural areas, alternative medicine may be the only available source of health care within reasonable distance. Some of older people who once lived in rural settings but who are currently residing in urban communities may have used alternative methods some years back prior to relocating to urban setting such as Khayelitsha and Phillipi. Most commonly, most of these alternative methods are not documented; instead they are passed by word of mouth from generation to generation (Mtyaphi, 2001; Buhrmann, 1983). Indigenous knowledge is an important part of South African's cultural heritage that can be used to address the problems of minor health ailments in communities that have distant health services, which are not reachable to other people. Furthermore, indigenous health knowledge system can be used to decrease the big demand and dependency on Primary Health Care services for management of minor health ailments. This knowledge is currently precious because there are few older people who are still carrying it (Mtyaphi, 2001).

While it is important to consider the migration experience in terms of cultural change, it is also important to ground this in terms of possibly more significant change in political, economic and social context (MacLachlan, 2004). These significant changes do have direct impact on the health system. People who move from their place of origin, have to adapt to conditions of the place where they currently dwell.

People from rural society have migrated from rural setting to urban in order to seek work. On their arrival in those urban settings such as Khayelitsha and Phillipi, their lifestyle had to adapt according to their new setting (Mtyaphi, 2001). Most of the roles and responsibilities that they were doing in rural settings have changed. For instance older people were used to do household chores by themselves. This was affected because on their arrival to urban cities, that was taken over by their children and their daughter-in-law. They used to do physical activities in the form of gardening. This was affected by lack of space and limited resources in cities. Inter alia those changes, health was no exception, health issues have also changed according to their current setting. These changes had completely affected their lifestyle in that they visit health centers for health problems instead of getting herbs from the garden and utilize it for health problems.

Most people who reside in Khayelitsha and Phillipi communities have relocated from rural areas in order to seek for work in urban setting, but some of them have relocated due

other reasons such as chronic health problems. They decided to come to an urban setting in order to seek help. Some of older people in these communities have other reasons for having relocated from rural to urban areas. In rural areas (mainly former Transkei and Ciskei) health facilities are far from the people. In these previously mentioned areas, some people are still using available resources in order to manage health problems experienced (Bhat *et al*, 1995). In this current era, it is assumed that older people can still retain that important role of managing health issues in Khayelitsha and Phillipi communities.

The fact that most of the older people who are residing at Khayelitsha and Phillipi communities have relocated from their points of origin, has resulted in changes in the roles and responsibilities that they had assumed before. The following questions can be asked when the researcher is trying to highlight crucial roles that they held.

- What role do they play in their new setting?
- Are they given the same respect and dignity they use to get before?
- Are they still principal heads of their families?
- What role can older people who provided health care service back at home play in the new health setting?
- What happened to the indigenous knowledge system that they once held?

This study is hoping to provide some answers to these questions and also hoping to utilize the indigenous knowledge in health transformation by making necessary recommendations. Despite the fact that older people who are currently residing in Khayelitsha and Phillipi communities are few and some of them have resided there for a long period of time, they still retain indigenous knowledge because it is knowledge that they used over and over for years (Mtyaphi, 2001).

2.5 Perspectives on the current health system

The study originated from a Primary Health Care setting in the Khayelitsha and Phillipi communities. The study was prompted by overcrowding in CHC's in these communities. Questions had been raised regarding the real purpose of the ANC government's 1996 implementation of Primary Health Care. Hence the researcher found it important to explore the era of colonizers and missionaries, birth of Primary Health Care

(internationally, nationally, Western Cape); South African problems with PHC and also success stories about PHC (South African and internationally).

2.5.1 The era of colonizers and missionaries

In South Africa, before the era of colonialism and Christian missionary settlement, the health of the African people were attended to by a wide range of indigenous health workers namely traditional doctors, herbalist and traditional midwives (Ngada & Mofokeng, 2001). It was not western qualified people or known professional health workers who conducted healing, ordinary workers were able to heal common diseases (Ngada & Mofokeng, 2001). In that era, people learnt healing methods from their parents (Mtyaphi, 2001; Guma, 2004). Healing of any common disease was not a complex procedure. It was performed by older people or any knowledgeable person in that family (Ngada & Mofokeng, 2001).

Colonizers and missionaries brought dramatic changes in the daily lives of black people including health (Ngada & Mofokeng, 2001). Healing by traditional healers was suppressed and was labeled as evil (Kubukeli, 1999). Western views of civilization and Christian values were given the upper hand (Ngada & Mofokeng, 2001). It became a disgrace to seek the restoration of one's health through the traditional ways of healing. During the 19th century, British colonizers constructed military and civilian hospitals and people were encouraged to utilize them. During the period of 1919 and 1940 health policies were developed. These policies were governing health facilities available at the time. Those policies were discriminatory and based on race.

2.5.2 The birth of Primary health care

2.5.2.1 International perspective of Primary health care

Primary Health Care first emerged on September 12, 1978 when the World Health Organization developed a strategy for health for all by the year 2000. It called for the attainment of an acceptable level of health care to be evenly distributed among the populations (Denhill *et al*, 1999). The Alma Ata Declaration aimed to rationalize the highly technical approach to health and to broaden the cover of provision of better basic

services to the population (Denhill *et al*, 1999). At the conclusion of the Alma Ata conference, a declaration was drawn and the following principles were set out in terms of which P.H.C services could be universally established:

- Equitable distribution through health education.
- Community involvement.
- Focus on prevention.
- Appropriate technology.
- Multi-sectoral approach (Denhill *et al*, 1999).

These principles indicate that WHO envisaged a service that is relevant to each country's situation. These principles were set in such a way that health services would be relevant to the community's needs and form an integral part of the community.

2.5.2.2 National perspective on P.H.C.

Although South Africa was not part of the Alma Ata declaration in 1978, it embarked on a series of PHC experiments and started implementing principles adopted at the conference. The challenge facing South Africa was that the health system had evolved from different origins. The two main contributors were Western medicine and the various African cultures with their traditional medicine. This has resulted in the development of two health systems in this country, alongside each other, with Western medicine having official status and traditional medicine not recognized (Denhill *et al*, 1999).

Emphasis on PHC was taken a step further in 1989 when the National Health Policy Council accepted a resolution stating that the only way to provide an affordable health service to all the inhabitants of the Republic of South Africa was by means of a partnership between the state and the private sector on the National Health Service Plan. This new direction for health was given backing by the National Policy Health act, No 116 of 1960.

In 1986 the Department of National Health and Population Development established a committee on PHC to identify ways to implement the national health plan. A document was produced to identify strategies or plans of actions for implementing PHC in South

Africa. National strategies took into consideration political, social, economic and technical factors (Denhill *et al*, 1995).

In 1992 the Department of Health set out components of Primary Health Care as set by the World Health Organization (WHO). These components were set out in form of objectives. These objectives were as follows: -

- To make information concerning the prevailing health problems and the method of preventing and controlling them available to the public.
- To promote the provision of food and proper nutrition.
- To ensure an adequate supply of safe water and basic sanitation.
- To ensure the provision of maternal and child health services.
- To ensure immunization against the major infectious diseases.
- To prevent and control local endemic diseases.
- To treat diseases and injuries appropriately.
- To ensure the provision of essential medicine.

This clearly showed that the Department of Health was aiming to provide services ranging from prevention to curative and also providing comprehensive health services to the people of South Africa (Denhill *et al*, 1999).

After 1994, the South African government adopted Primary Health Care as a strategy to decentralize health services with the emphasis being placed on community. District health systems were implemented in 1996 and an attempt was made of providing each community with its own clinic or day hospital. The most important function of the authorities was to provide Primary Health Care (PHC) services to all members of the community (Fry & Hasler, 1986). According to Owen (1995), health authorities of PHC may not deny access to public sector health services to any person on the grounds that they reside outside the area of that authority. This means that a health service in the community is accessible to everyone. It is on these grounds that most people utilise health services for their health needs.

2.5.2.3 The implementation of PHC in the Western Cape

At the second tier of government (provincial level), there are nine provinces namely Limpopo, North West, Mpumalanga, Gauteng, Kwazulu-Natal, Eastern Cape, Free State,

Northern Cape and one is the Western Cape. Like the other provinces, it has its own provincial legislature. Each provincial authority is responsible for all aspects of health required by the people of that province, which include emergency care, hospital care, environmental safety and a suitable referral system. These provincial authorities are also responsible for the support, monitoring and evaluation of services provided at district level (Denhill *et al*, 1999).

At district level each province was divided into districts according to functional and demographical determinants. The size of each district was determined by the size of its population. The district health authorities will be accountable for the elected political authorities and all community health services, private and public, will be their responsibility. The most important function of the district health authorities will be to provide PHC services to all members of the community. These authorities will receive and allocate the budget to supply these services. Services will include clinics, CHC's, community hospitals and emergency services (Denhill *et al*, 1999).

The community health centers (CHC's) are the tools that were established to address the implementation of the Primary Health Care (PHC). Primary Health Care was introduced in response to wide recognition that the Western medical system was failing to adequately improve health in poor countries (Jeebhay, Hussey & Reynolds, 1997). World delegates introduced Primary Health Care through the Alma Ata Declaration in 1978 as described previously. It was introduced as the strategy that would address the social and political determinants of health worldwide (Jeebhay *et al*, 1997). The South African government has implemented CHC's and clinics as the strategy to bring health resources to the people and addressing the needs of the communities. It is these CHC's that are overcrowded on a daily basis in communities such as Khayelitsha and Phillipi.

2.5.3 Problems with the implementation of PHC in South Africa

The South African government is facing many challenges that intertwine among each other and impede the progress of programmes implementation. One of the major social problems that face South Africa as well as areas under the study is poverty. This is directly proportional to the high rate of unemployment (Statistics South Africa, 1996). Most people who reside in informal settlement are vulnerable to infectious diseases and

that resulted in over-utilization and overcrowding of community health centres (Keeran *et al*, 2000). Also the fact the government of the day introduced free health services to certain vulnerable groups, has also contributed to people flocking to the community health centres for their health needs.

Primary Health Care in South Africa has been designed to be a nurse driven program. Nurses in South Africa have been trained in a Western medical model. Strategies and methods that are used in community health centres have been a purely modern western medical approach. This model does not accommodate other aspects of health that the community values. Primary Health Care in South Africa as well as in the world has failed to address some pertinent issues during its implementation such as inter-sectoral collaboration, acknowledgement of current resources in the communities and recognising the various health workers that are already in existence in our communities (Jeebhay *et al*, 1997). In the South African context, there is a problem of not recognising the treatment outside community health centres. If a sick person has been seen or treated by a traditional healer before coming to community health centre, a nurse will occasionally shout at that person and discourage treatment outside community health centre (Keeran *et al*, 2000). The Primary Health Care system has been design in a manner that is a top-down provision of health service (Denhill *et al*, 1999). Services rendered are not people-centred, instead, they are facility-focused or institution-based. This creates animosity and prejudice among health authorities at primary level and in the community at large. According to the address made by Ms Ochala-Odhiamo on strengthening Primary Health Care in South Africa in 2004, community participation is vital; therefore there is a need to develop partnerships between communities and health authorities.

But in these communities (Khayelitsha and Phillipi), day hospitals are not the only source of addressing health needs; there are also other service providers that people use. There are also traditional health providers (traditional healers), private doctors and pharmacists. The people living in these districts utilize all these resources to help in maintaining stable health in each family. So other fraternity such as the above mentioned will need to be involved in community participation.

2.5.4 Some success stories about PHC in South Africa and internationally

In countries like Australia, the Primary Health Care model works well. Aboriginal and Western cultures exchange very well, staff at the health centres provides traditional bush medicine to both Aboriginal and Non-Aboriginal patients. Cooperation of these two has resulted in a holistic and multidisciplinary approach to health and health care. It has also broadened community and the health workers' perspective on health care. Canada has also shifted in the same direction of recognising traditional midwives (Jeebhay *et al*, 1997). Traditional midwives in Canada have been included in the state financed health system.

In Africa, health and related socio-economic indicators has put Africa among least developed regions in the world (Denhill *et al.*, 1995). This is due to social factors that cripple quality of care, such as infant mortality rate, safe water supply and life expectancy. In 1985, Ministries of health of the African region of the WHO committed themselves to use PHC approach to strengthen their national health status (Denhill *et al*, 1995).

In Mozambique, national Non-Governmental Organisations (NGO's) also play important role in improving delivery of health and other social services (Jeebhay *et al*, 1997). These NGO's assist the local health sector by supporting the training of health workers and traditional midwives.

Likewise in Uganda, Traditional Birth Attendants (TBA's) take greater responsibilities of improving social service like health (Jeebhay *et al*, 1997). These TBA's look at network information, advocacy and mobilization. They also form linkages between communities and the national level policy decision makers. These TBA's play a greater role in the implementation of PHC at the rural level and strengthen the women's movements in Uganda.

Prof. Mooney of Australia reinforces that community voices need to be heard and ensure that communities get necessary skills to be participants in Primary health care (Department of Health, 2004). Therefore it is imperative that the voice of the older people

be heard on how they used to manage health problems and reconcile that with the current health system. But safety measures need to be tightened as health of a human being is important.

In countries such as Brazil, health council are made up of 50% community representative with others being government representative and private health care providers (Department of Health, 2004). This implies that health development in this country could also involve all stakeholders. Could we envisage a future like this in South Africa? It would have been better if in the South African situation, a model that is initiated by National Health Department be established in Primary Health Care level. This model would be addressing health issues at primary level and ensure that all stakeholders including the older people with their valuable knowledge are involved. This model would comprise of health professionals, traditional leaders, political leaders, youth and older people.

2.6 List of minor ailments according to western medicine

The researcher has listed below the minor ailments as categorized by Western medicine. This list will be used as model of comparing what older people mentioned as minor ailments to what Western medicine outline as minor health ailments. Clinically it has been difficult to get specific ailments mentioned as minor health ailments, instead most writers classify ailments between acute and chronic. According to McWhinney (1997) acute illnesses can be managed within a short period of time. Barber (1984) also affirms this by outlining some minor health ailments that are similar to McWhinney's list. All the listed minor health ailments were confirmed by the medical officers at Khayelitsha CHC as minor health ailments.

Table 1 illustrates the list of minor health ailments that was used as a model to compare to what older people regard as minor health ailments.

Table 1 List of minor health ailments according to McWhinney (1997) and Barber (1984).

▪ Back pain - (Umqolo obuhlungu)
▪ Colds - (ukukhohlela)
▪ Conjunctivitis - (Amehlo abuhlungu)
▪ Constipation - (ukuqhineka)
▪ Diarrhoea - (Isisu esihambisayo) ✕
▪ Earaches - (Indlebe ebuhlungu)
▪ Headache - (Intloko ebuhlungu)
▪ Sore throat - (Umqala Obuhlungu)
▪ Toothaches - (Izinyo elibuhlungu)
▪ Vomiting - (Ukugabha)
▪ Wind - (Umoya)

The ailments listed in Table 1 showed 11 health ailments that are considered to be minor ailments in the Western medical model. These minor health ailments are frequently presented minor ailments. They will be compared to what older people perceived as minor ailments and will be used as a reference list when the researcher discusses the results.

Having noted the fact that older people trust their methods of managing minor ailment, the researcher felt the need of the classification of the management strategies. The researcher used the model of Van Wyk, Van Oudtshoorn and Gericke 1997. According to Van Wyk *et al.* (1997), there are different forms of treatment administration methods. They are listed the following time tables and each of these has been clearly defined. All these treatment administration methods were used by the older people when they were managing the minor health ailments. These treatment administration methods are briefly described in the Tables 2 and 3 respectively.

Table 2 Description of different treatment administration methods of western medical model.

Treatment administration method	Brief descriptions of these treatment administration methods
Enemas	Solutions intended for rectal injection
Extracts	Preparations containing the active principle of crude drugs.
Infusions	Preparations by maceration of crude drug for short period of time in cold or boiling water.
Inhalants	Liquid preparations composed of volatile ingredients which when vaporised are intended to contact respiratory tract.
Linctuses	Liquid preparations containing sugar and medicinal substances. These can be swallowed without water addition.
Liniments	Liquid or semi-liquid preparations, which are intended for external application.
Lotions	Liquid preparation intended for application to the skin.
Mixtures	Liquid preparations intended for administration by mouth.
Nasal drops	Liquid preparations for instillation into the nostrils.
Ointments	Protective preparation on the skin.
Tinctures	Liquids containing active principles of vegetable drugs.
Snuffs	Preparations of finely powdered dried medicinal plants that can be drawn up into nostrils.

Table 2 shows twelve treatment administration methods. These methods can be used when any person uses home based medicines. Each of the methods serves a different purpose. Each treatment method will be illustrated in the following objective of each focus group. Each treatment method is aligned with method of administration of any home based remedy.

In the next Table 3, methods of administration of home-based medicine as used in application to different areas of the body.

Table 3 Description of methods of administration to different areas of the body.

Method	Description
Orally	Infusions, syrups and tinctures are often taken by mouth. Purging is the other method of oral treatment.
Sublingually	Some remedies are taken under the tongue and it is where rapid absorption happens.
Rectally	Infusions and decoction are administered as enemas using syringes. Enemas are good for health maintenance and remedy for constipation.
Topically	Medicine that is directly applied on the skin. Infusions, decoctions, tinctures, lotions and lotions are applied on the skin.
Nasally	Dried and powdered plants used as snuffs. These induce sneezing
Smoking	Smoke may also be used to make patient cough to expel cause of illnesses.
Steaming	Steaming of plants in very hot water is good for health maintenance.
Bathing	Herbal mixtures may also be added to relieve certain conditions such as measles (Van Wyk <i>et al</i> , 1997)

Table 3 illustrated different methods of administering western medicine to different areas of the body. These methods are also used by older people in the management of minor health ailments. These methods will be compared with what older people use as administration methods.

2.7 Summary of Chapter 2

The community health centres at Khayelitsha and Phillipi are overcrowded daily with clients presenting with minor health ailments. This study is aiming at exploring the indigenous knowledge carried out by older people in the management of minor health ailments. Older people residing in these communities have perceptions that minor health ailments could be managed and contained within a home environment using indigenous knowledge that is carried by them. Though there is paucity in the literature relevant to this topic, the researcher attempted to explore literature on various concepts such as culture and health specifically within the rural South African context that have evolved illness representations that can accommodate not only new diseases but new epistemologies

(Liddel *et al*, 2004). Rapid changes in the South African landscape regarding immigration and urbanisation has had an impact on health belief models and changing roles of older people (from being heads of the families to being subordinates in senior citizen centres).

This has not happened in isolation, the ANC led government has also brought some changes with the aim of making health accessible and affordable by introducing PHC strategies. Despite the notion of a comprehensive health system that is accessible, comprehensive health appears to be eluding the majority population of South Africans, especially the previously disadvantaged communities.

Questions are raised regarding the process of implementing PHC, such as whether it considered the primary resources that lie dormant within each household setting and community. South Africa is not the only developing country that has implemented PHC as a means of health service delivery. Countries like Uganda has traditional birth attendants who are in the front line of decision making in the Primary Health Care and in Mozambique, NGO's train the traditional midwives in order to render a service properly where it is needed. In South Africa steps are being taken to include traditional healers within the present health dispensation, especially at the primary level of care. There are also research initiatives targeting indigenous knowledge system. The National Research Foundation and Medical Research Council have focus areas on indigenous knowledge systems, hence the current study. Would the Department of Health acknowledge the indigenous health knowledge of older people within PHC settings?

There are myths and misunderstanding about usage of indigenous knowledge. These arise because of lack of knowledge and understanding of cultural values and beliefs. Hence the researcher is exploring the indigenous health knowledge to help clear the myths around it to try and bring the importance of indigenous health knowledge to the forefront.

There is not enough emphasis on the value and contribution of older people and the indigenous health knowledge they carry in many aspects of life including the management of minor health ailments. According to the literature reviewed by the researcher there was no study of this nature that had been conducted in South Africa.

CHAPTER 3

METHODOLOGY

3.1 Aim of the study

The aim of the study is to determine the indigenous health knowledge and attitudes of the older people living in Khayelitsha and Phillipi regarded the management of minor health ailments in a home setting.

3.2 Objectives

The objectives of this study are:

- To describe the study setting and the demographic details of the sample and participants.
- To determine what the older person regards as minor health ailments.
- To determine home-based methods and strategies used for the management of minor health ailments.
- To determine when the older person would regard that their strategies are not working and refer to an outside source and to determine which source would they refer to?
- To verify terminology of the home based medicine by collaborating with the institutions (U.C.T. School of Medicine and U.W.C. Pharmacy Department) for English or specie name terminology of these herbs.

3.3 Study Design

This was a descriptive study that focused on the phenomena of indigenous health knowledge systems related to management of minor health ailments by Xhosa speaking older people who reside in Khayelitsha and Phillipi communities. The study examined both qualitative and quantitative aspects.

The extensive description of the nature of minor health ailments and home based strategies used to manage minor health ailment. To examine this phenomena further, focus group were used to stimulate discussion among older people. A focus group is a technique whereby 7-10 participants are asked questions in order to encourage discussion

and the expression of differing opinions (Marshall & Rossman, 1995). The reason for using this method is that focus group is relevant for organized group discussion around a certain theme. In focus group, selected participants discuss about specific topic relevant to situation (Vaughn, 1996).

The quantitative aspect focused on the measurements of the home remedies used to manage minor health ailments by older people. Furthermore, the study explored the cut-off points of the use of home-remedies when they are not working and to further determine what older people did when the remedies were not effective. This information was presented in tables and percentages.

3.4 Study setting

Khayelitsha and Phillipi communities are approximately 26 km and 20 km from the city center of Cape Town, respectively. Most people living in these communities experience social problems such as poverty, unemployment, overcrowding, and crime. Khayelitsha has an approximate population of 1000 000 people whereas Phillipi has approximately 500 000 people (Statistics South Africa, 1996). These communities will be discussed in details separately.

Khayelitsha is a developing township that has a lot of facilities. This township has a community forum called Khayelitsha Development Forum (KDF). This forum oversees all the facilities available in this community (from inception to sustenance). It also has a Health Forum that overlooks health issues and collaborates with the health centers with regards to information sharing. Unlike other townships, Khayelitsha has most essential services such as social services, regional court, traffic services, recently opened Home Affairs office and six public libraries.

This township has tarred roads even in-between the houses. There is running water and sanitation. There are three modes of transport here namely, trains, busses and taxis. In terms of recreation, there is one swimming pool, a golf course, sports fields, a stadium, and eight community halls which are utilized for indoor games.

This community has three community health centers that are managed by Provincial Administration of Western Cape (PAWC) and six clinics managed by the Local Authority. There are also approximately 20 private doctors that are also a health resource for the area. There is one pharmacist who helps with private dispensing of medication. There are also traditional healers available in the area, which are also a health resource for people within these communities.

Khayelitsha has been identified as one of the areas that were targeted by the president for development for the 2010 Health Plan. The government has adopted a strategic plan (2010 Health Plan) that aims at developing the health services across the country over the stipulated period of time. Outcomes of this study aims to influence Primary Health Care development, which is a component of the health system. Therefore, the outcomes of this study might contribute towards the 2010 Health Plans through utilization of indigenous knowledge carried by older people for controlling overcrowding CHC's.

Despite these developments related to Khayelitsha, there are social problems surrounding people residing in this township, such as poverty and unemployment. These social problems are manifested in many informal settlements. In those informal settlements, there is poor sanitation, no running water, and no toilets. These social hazards affect the health of the people residing in these informal settlements. According to Statistics South Africa (1996), populations of people residing in these areas are growing bigger and bigger each year. Due to unemployment, most people residing in these informal settlements utilize government health facilities for their health needs (Keeran *et al*, 2000). The continuous growth of the population of this area has a direct impact on overcrowding of these CHC's day by day. Also according to the Batho Pele, which stipulates that all people have a right to treatment and should not be turned away on this account, they therefore access CHC's.

Phillipi is also another small township but it is not as well resourced as Khayelitsha. It has running water, sanitation and tarred roads. Just like Khayelitsha, it also does have its areas that have informal settlement with no running water and sanitation. Transport used in this area is taxis and trains. There are 2 health facilities, one is operated by PAWC and one is operated by the Local Authority. There are also traditional healers in this area used by some people who require health advice.

3.5 Study population

The study population consisted of older persons (refer to definition of terms in pg vi) residing in the Khayelitsha and Phillipi districts of Cape Town. Some older people living in these communities are attending senior citizen centres available in these communities during the day. In these centres they do stimulation activities that will maintain their minds and bodies within a reasonable state of health. Khayelitsha has six senior citizen centres and Phillipi has two.

3.6 Study sample and sampling methods

There are six senior citizen centres at Khayelitsha and two at Phillipi. All these senior citizen centres run as day centres except for one in Khayelitsha, which is called Neighbourhood Old Age Home (NOAH), that operates as a residential home for older people with no home or relatives to look after them. Khayelitsha have six senior citizen centres, three were randomly selected. Phillipi has two senior citizen centres one was randomly selected. Demographically and geographically, Khayelitsha is bigger than Phillipi so as a means of allowing fair representation, more centres were selected from Khayelitsha (Marshall & Rossman, 1995). Hence the researcher has randomly selected three senior citizen centres at Khayelitsha and one from Phillipi. The randomly selected senior citizen centres at Khayelitsha are Noxolo, Mzamomhle and Masithandane. The one randomly selected senior citizen centre from Phillipi is Masiphumelele.

The senior citizen centres had various numbers of older people in their centres. Noxolo had 50, Mzamomhle had 70, Masithandane had 45 and Masiphumelele had 120. The researcher chose a convenient sample (Marshall & Rossman, 1995) from those older people who were willing to participate voluntarily in the study. Marshall & Rossman (1995) maintain that focus group must have 7-10 participants. The numbers in each focus group ranged from 8 to 10 older people who were willing to participate in the study. Noxolo focus group had nine participants, Masithandane focus group had nine participants, Mzamomhle focus group had also nine participants, and Masiphumelele focus group had ten participants. The researcher reasoned that if there were not enough participants from the randomly selected senior citizen's centre, he could have further randomly selected another senior citizen centre for an additional focus group from that

centre. There was no need to do this as all focus groups had the required number of participants.

3.7 Eligibility criteria

3.7.1 Inclusion criteria

Participants were included in the study sample on the basis of the following-

- Older people that reside in Khayelitsha and Phillipi who still have indigenous health knowledge.
- Older people who agreed to participate voluntarily and signed consent forms.
- Older people who belong to the randomly selected senior centres.
- Older people who use / have used indigenous knowledge for health problems.

3.7.2 Exclusion criteria

Participants were excluded from the study sample on the following basis:-

- Older people who objected to take part in the study.
- Older people who do not reside in the areas under the study.
- Older people who never used indigenous knowledge for health problems.
- People who do not fall in the category of older people.

3.8 Instrumentations

3.8.1 Methods of data collection

The researcher used focus group interviews with an interviewing schedule. In this study, recruited participants were discussing the issue of management of minor health ailments by older persons using indigenous knowledge. The interviewing schedule contained four unstructured questions guide the interview. The questions that were asked were as follows: -

1. What are the common illnesses that the Makhulus and Tatomkhulus used to manage at home?
2. What were the home remedies that they used in managing these minor illnesses?
3. When would older person give up using home remedies and refer to an outside source?
4. Who would they be referring to for further management of the illness?

All these questions were asked with the purpose of exploring what older people regarded as minor ailments in their time and the methods and strategies that they used in managing of those minor ailments. These questions also determine the cut-off time of using home remedies especially when a sick person is not getting better. Questions also determined the referral source that they used for further management.

The researcher considered the aim of the study, study sample of older people and the study design chosen and concluded that focus groups using an interview schedule were relevant method of data collection. The other reason for using this method of data collection is that a focus group is a relevant data collection method for organised group discussions around a certain theme (Vaughn, 1996). The researcher is a trained professional in group facilitation and that has been an advantage for the method of data collection chosen.

3.8.1.1 Advantages of focus group interview

- The participants shared views and thoughts together.
- The participants mirrored each other in terms of validating the information (Vaughn, 1996).

3.8.1.2 Disadvantages of focus group interview

- There were no individual responses
- Some participants were influenced by the others in terms of answering questions during the process of the focus group interviews (Vaughn, 1996).

- Research assistants needed training in capturing data before the process of focus group interviews as they were not experienced like the researcher who had been trained in focus group facilitation.

3.9 Procedure

3.9.1 Pilot study

A pilot study was conducted at Michael Mapongwana CHC at Khayelitsha in order to test the study design, data collection method and analysis of the data of the study. The researcher recruited the older persons who belong to the Makhulu and Tatomkhulu project. This core group (Makhulu and Tatomkhulu project) is the one this was mentioned in Chapter 1, which existed from discussions of communities and health professionals regarding overcrowding of CHC's with clients presenting with minor health ailments. Focus group interviews were used to collect data. This method of collecting data was effective and it was also used for the data collection of the actual study. Initial problems experienced was data capturing collection methods in writing down of data with the use of a scribe. There was not enough accuracy with data captured. Hence the researcher improved this method by using audio –tapes and having two scribes for collecting data. Permission was asked for using this method from the participating older people.

3.9.2 Implementation

The researcher started the process by writing letters to the managers of those randomly selected senior citizens' centres. In the letters, the researcher asked permission to conduct the focus groups (see Appendix 1 in pg 27). The managers of all the four senior citizen centres responded by allowing the focus group to take place.

The researcher visited the randomly selected centres in order to establish the focus groups, and also to give further explanation to the managers about the study. The researcher then introduced himself to the older people and explained the aim of the study. After that, he recruited the Makhulus and Tatomkhulus who had indigenous health knowledge and were willing to participate in the study. When he completed the

recruitment process, he arranged dates and times to conduct focus groups and evaluated the venue to determine whether it was conducive to run focus groups.

On the day of data collection, the researcher explained to the older people the purpose of signing consent form (see Appendix 2/3 in pg 28/29) and requested the willing participants to sign. This was done prior to participating in the focus groups. He gave the older people the assurance that information gained will be treated with confidentiality.

The researcher prepared the venue before running the focus groups. He ensured that all the venues for the focus groups were quiet and did not have distractions. The researcher started by welcoming every participant, and then he explained the purpose of the group discussion (focus group interview). He ensured that sitting arrangements were suitable for everyone by allowing each participant to sit in a circle in order to maintain eye contact with each other.

The researcher welcomed every participant and immediately introduced the research assistants. The research assistants were two young female who were members of the Makhulu and Tatomkhulu project. The researcher began by posing first question of the interview schedule (see appendix 4/5 in pg 99/100), and then allowed participants to discuss and conclude on agreed answer. The other questions were asked in the same manner. Average time for each focus group was four hours with short breaks in between. Each focus group was planned for its own day, hence each focus group was arranged prior the actual date. Data was collected using audiotapes and other information was written by the research assistants. Permission was obtained from older people before using the audiotape. When the researcher finished each focus group, he interviewed each participant of that centre for his/her demographic details (see Appendix 7 in pg 102).

All the data collected from the older people was transcribed and formatted. Data collection took approximately two weeks for older persons in Khayelitsha and one week for the older persons in Phillipi. Data analysis took approximately two months.

The researcher collaborated with other institutions (University of Cape Town and University of the Western Cape) for the terminology of the herbs mentioned by the older people. These institutions helped with English and Specie name of the herbs or plants mentioned by older people.

Permission was asked from participants to disseminate the outcome of the study to the relevant stakeholders, publication in journals and presented at conferences.

3.10 Data Analysis

3.10.1 Qualitative analysis

The following steps were taken in the process of qualitative data analysis.

- Data management
- Content analysis

Data management

Data from the focus groups were transcribed and translated into English as the interviews were done in isiXhosa. The transcriber was made aware of confidentiality. The transcriptions were checked by the researcher to ensure that the information on the transcripts was the same as that on the audiotapes.

Content analysis

Content analysis refers to the process of identifying, coding and categorizing the pattern within the data. The researcher went through each of the transcripts and identified those sections that were related to objectives. The researcher related to the identification of the section to the thick descriptions of minor health ailments and the strategies use for managing them and use also medicinal purpose of herbs and remedies.

3.10.2 Quantitative analysis

The quantitative aspect focused on the effectiveness of the strategies used to manage minor health ailments by examining the measurement of the home-remedies used. Furthermore, the study explored the cut-off points of the use of home-remedies when they are not working. In this respect, it was determined to whom referrals made when the remedies were not effective. This information yielded results which were presented in tables and percentages.

3.11 Validity, Reliability and Biasness

The sensitivity of the instrument chosen was evaluated during the pilot study and necessary changes were made thereafter. Research assistant were trained on the use of instrument and accurate ways of documenting data. To enhance reliability the research assistants practised their role during the piloting of the study and further measures were used in the actual study of using audiotapes for accurately collecting the data. Questions were repeated to gain clarity where necessary. To minimise bias the researcher asked questions in the same manner in all focus groups so that at the end there was minimal or no errors. Research assistants did transcribing of data and the researcher re-checked the data. Older people validated each other by discussing each point thoroughly then agreed on it before documentation.

University of Cape Town

CHAPTER 4

PRESENTATION OF RESULTS AND DISCUSSION

The primary aim of the study was to determine the indigenous health knowledge and attitudes of the older people living in Khayelitsha and Phillipi regarding the management of minor health ailments. The results of this study will be presented in alignment with the objectives. After the presentation of the results of each objective, the researcher will immediately discuss the data for that specific objective. Objective 5, which states that the researcher will verify terminology of the home, based medicine by collaborating with the institutions (UCT School of Medicine and UWC Pharmacy department) for English or Species name terminology of these herbs. The researcher sent all the names for translation but not all Xhosa terms had English or Specie name. Those translated words will be used throughout the document.

4.1 Objective 1: To describe the study setting, the demographic details of the sample and demographic details of willing participants.

4.1.1 Demographic details of the sample

Khayelitsha and Phillipi communities have senior centres. The researcher interviewed the manager of all those randomly selected senior citizen centres (see Appendix 6 in pg 101). It is in these centres where older people spend much of their time during the day and where they do recreational and social activities. Khayelitsha has six senior centres and that includes one old age home that is currently in this community. The Old age home has both day and night facilities, and serves as a residential facility for older people who do not have people to look after them. The other five senior centres operate during the day, open from eight o'clock until four in the afternoon. Existence of senior citizen centres in African township is contrary to their traditional lifestyle. African people have a tradition of looking after older people. It is traditionally the duty of daughters-in law or their own children to look after older people in African families. But migration and urbanisation has contributed to the current settings of senior citizen centres in African townships (Mtyaphi, 2001).

There area limited number of older people who live with their families. Although the exact number was not established. According to the Department of Social Services in these communities, older people in these communities attend senior citizen centres during the day and rejoin their families in the afternoon.

Three senior centres that were randomly selected by the researcher were Noxolo, Mzamomhle and Masithandane. Each centre will be discussed separately. In Phillipi there were two senior citizen clubs, and the researcher randomly selected Masiphumelele senior citizen centre.

Noxolo Senior Citizen Centre is located in Khayelitsha in a sub-unit called A-section. Ms L. Jokwana is the manager of this club. It was established in 1989 with the purpose of providing support to older people who reside in the nearby area. Older people who reside in the area and who are interested in joining this club are required to pay R5.00 annual joining fee. Then they are required to pay R43.00 a month which helps in the daily running of the centre; purchasing of food towards their breakfast and lunch. The Department of Social Services is the main funder of this senior citizen centre. During the day, older people spend their day participating in crafts, exercise and social skills.

Mzamomhle Senior Citizen Centre is located in Khayelitsha at a sub-unit called Makhaya. Ms N. Langa is the manager of this club. It was established in 1992 with the purpose of providing support to older people who reside in the nearby area. Older people who reside in the area and who are interested in joining this club are required to pay R5.00 annual joining fee. Then they are required to pay R20.00 a month which helps in the daily running of the centre. This money helps with purchasing of food which helps towards their breakfast and lunch. Ikamva Labantu is the main funder of this senior citizen centre. During the day, older people spend their day on knitting, sewing and exercises.

Masithandane Senior Citizen Centre is located in Khayelitsha at a sub-unit called Harare. Mr W. Dyilitye is the manager of this club. It was established in 1996 with the purpose of providing support to older people who reside in the nearby area. Older people who reside in the area and who are interested in joining this club are required to pay R5.00 annual joining fee. Then they are required to pay R20.00 a month which helps in the daily

running of the centre, helps with purchasing of food which helps towards their breakfast and lunch. Ikamva labantu is the main funder of this senior citizen centre. During the day, older people spend their day on knitting, sewing and beadwork.

Masiphumelele Senior Citizen Centre is located in Phillipi at a sub-unit called Lower. Mrs M. Madlomo is the manager of this club. It was established in 1998 with the purpose of providing support to older people who reside in the nearby area. Older people who reside in the area and who are interested in joining this club are required to pay R5.00 annual joining fee. Then they are required to pay R50.00 a month which helps in the daily running of the centre, helps with purchasing of food for their breakfast and lunch. This senior citizen centre does not have any sponsor or funder. During the day, older people spend their day on knitting, sewing and crafts.

4.1.2 Demographic details of participants.

The researcher administered a questionnaire for each participant after the focus group interview (see Appendix 7 in pg 102). Table 4 outlines the demographic details of the participants.

Table 4 Demographic details of the participants

	Noxolo Senior Citizen Centre	Mzamomhle Senior Citizen Centre	Masithandane Senior Citizen Centre	Masiphumelele Senior Citizen Centre
Average age	70	67	67	61
Participants	9	9	8	10
Average years staying in peri-urban area	23	19	27	14
Males	4	3	2	3
Females	5	6	6	7

The information in Table 4 shows that the average age of the participants in all four focus groups ranged from 61 to 70, there were more females than males, the number of

participants in the study ranged from 8-10, and the average stay in the peri-urban area (Khayelitsha and Phillipi) was different from focus group to focus group.

4.1.3 Discussion of objective 1

Although all these senior service centres were open for different numbers years, they all have existed for less than 20 years since they were established. This might be related to the fact that Khayelitsha and Phillipi are fairly new peri-urban areas and community resources such as senior citizen centres only developed more recently. The whole idea of older people utilising facilities such as senior citizen centres is something new to the black communities, and is contrary to the traditional practise of extended families.

Considering the fact that older people can be forgetful, and for not practising home-based remedies while staying in a senior citizen centre for a long period of time, this might have negatively impacted on their memory carrying indigenous health knowledge. Nonetheless, during the process of data collection and through their participation in the focus groups, they reminded each other to remember the information on their use of home-based remedies.

Each club has a set programme of arts and crafts activities that they do during the day and they are similar in all these senior clubs. This is a change in lifestyle of older people. The average age of all the participants is 66 years and the average duration of stay in Cape Town for all participants is 20 years. This shows that some of the older people have been in the peri-urban for a long time. This may mean that they are acquainted to urban life. The average number of participants the four focus groups was nine, which is within the range of 7-10 participants in a focus group (Marshall & Rossman, 1995). The joining fee of R5 per year is a common to all the centres. Despite the fact that different sponsors or funders them, they have a monthly contribution that they pay each month. Having considered the fact that older people are mainly pensioners, this amount is reasonable. According to one participant, sponsors do not give them enough financial support. Therefore they need to add a certain amount that will allow the activities to run smoothly. The activity programmes mean that older people's lifestyle have changed from their original one; instead these activity programmes have taken away the focus on families' health but is more focused on an individualist approach.

4.2 Objective 2: To determine what older persons perceived as minor health ailments

4.2.1 To determine what older people mentioned as minor health ailments.

Despite the fact that the question, was specifically about minor health ailments, it was found that the older people mentioned all the ailments that they were managing at home. Some of these ailments are perceived by the researcher as major ailments.

Table 5 is an illustration of the responses from all the focus groups on what older people perceived as minor health ailments. The names of ailments were translated into an English version and are presented in Xhosa first as older people in each focus group mentioned it and English.

Table 5 List of minor health ailments mentioned by older people in each focus group.

Noxolo	Masiphumelele	Mzamomhle	Masithandane
Focus group 1	Focus group 2	Focus group 3	Focus group 4
1. Ithumba Boil	1. Ihlaba Chest pain	1. Ithumba Abscess	1. Ithumba Abscess
2. Ihlaba Chest pain	2. Ukubelekisa Child delivery	2. Ukhothelwa ngumlambo Allergy	2. Isifuba esibuhlungu Chest pain
3. Ukubeleka Child delivery	3. Ukuqhineka Constipation	3. Umqolo obuhlungu Backache	3. Ukhohlokhohlo Coughing
4. Ukhohlo- khohlo Coughing	4. Ukhohlokhohlo Coughing	4. Ukutsha Burns	4. Ihlaba Chest pain
5. Indlebe ebuhlungu Earache	5. Indlebe evuzayo Ear discharge	5. Ihlaba Chest pain	5. Ukubelekisa Child delivery
6. Ubushushu Elevated	6. Ubushushu Elevated	6. Ukhohlokhohlo Coughing	6. Indlebe ebuhlungu Ear ache

Temperature	temperature		
7. Umoya omdaka Evil spirit	7. Ukuxhuzula Epilepsy	7.Iindlebe ezibuhlungu Ear ache	7. Ukuxhuzula Epilepsy
8. Intloko ebuhlungu Headache	8. Inyongo Excessive bile	8.Ubushushu bomntwana Elevated temperature	8. Imvuma/amehlo Eye infection
9. Umiselo Infertility	9.Amehlo / imvuma Eye infection	9. Amehlo abuhlungu Eye-ache	9. Isifesane /Ilido Finger abscess
10. Isinqe Low back pain	10. Umgqwaliso Face allergy	10. Ukophuka Fracture	10.Intloko ebuhlungu Headache
11. Isiluma Menstruation pains	11. Ukophuka Fracture	11.Intloko ebuhlungu Headache	11. Irhashalala Measles
12. Uqwilikane Mumps	12.Intloko ebuhlungu Headache	12. Iduma Head haematoma	12. Isiluma Menstruation pains
13. Ishimnca Newborn rash	13. Imasisi Measles	13.Isinqe esibuhlungu Low back pain	13. Uqwilikane Mumps
14. Ukudumba Oedema	14. Inkaba Navel extension	14. Imbilaphu Lymph node swelling	14. Ukudumba Oedema
15. Ingxuluba Post delivery Pains	15. Ishimnca New born rash	15. Imasisi Measles	15. Umqala obuhlungu Sore throat
16. i-Drop Sexual Trans- mitted Diseases (Male)	16. Uqwilikane Mumps	16. Uqwilikana Mumps	16.Isifuba esivalekileyo Tight chest
17.Umqala obuhlungu Sore throat	17. Ukukhulelwa Pregnancy	17. Ukumongoza Nose bleed	17.Unkonkonko Tuberculosis
18. Isisu	18.Isisu	18. I- drop	18.Izilonda

esilumayo Stomach-ache	esihambisayo Running stomach	Sexual Transmitted Diseases (Male)	Wounds
19. Igcushuwa Syphilis	19. Amafufunyana Schizophrenia	19. Iinyawo eziqaqambayo Sore feet	
20. Izinyo elibuhlungu Toothache	20. Umqala obuhlungu Sore throat	20. Ukukruneka Sprain	
21. Izilonda Wounds	21. Isisu esilumayo Stomach-ache	21. Isisu Stomach-ache	
	22. Ukugongqoka kwefokotho Suppressed fontanel	22. Igcushuwa Syphilis	
	23. Igcushuwa Syphilis	23. Izinyo eliquaqambayo Toothache	
	24. Unkonkonko Tuberculosis		

Table 5 showed that older people in each focus group had various numbers of what they perceived to be minor health ailments. Each focus group will be explained separately.

Noxolo Senior Club mentioned 21 minor health ailments that they said they use to manage at home. Table 5 shows that 6 of the 11 minor ailments mentioned by older people fall in the category of minor health ailments that are used as a reference in Table 1 (pg 27). This means that 55% of the minor ailments mentioned by older people at Noxolo senior club fall in the category of Western medicine minor health ailments.

Older people from Masiphumelele Senior Club mentioned 24 minor health ailments that they use to manage at home. Table 5 shows that 8 of the 11 minor ailments mentioned by older people fall in the category of minor ailments that are used as reference in Table 1 (pg 27). This means that 73% of the minor ailments mentioned by older people at Masiphumelele senior club fall in the category of Western medicine minor health ailments.

Mzamomhle Senior Club mentioned 23 minor health ailments that they use to manage at home. Table 5 shows that 6 of the 11 minor ailments mentioned by older people fall in the category of minor ailments that are used as reference in Table 1 (pg 27). This means that 55 % of the minor ailments mentioned by older people at Mzamomhle senior club fall in the category of Western medicine minor health ailments.

Masithandane Senior Club mentioned 18 minor health ailments that they use to manage at home. Table 5 shows that 5 of the 11 minor ailments mentioned by older people fall in the category of minor ailments that are used as reference in Table 1 (pg 27). This means that 45 % of the minor ailments mentioned by older people at Masithandane senior club fall in the category of Western medicine minor health ailments.

Not all ailments that were mentioned by older people in all the focus groups were part of the list mentioned in Table 5 of minor health ailments. Some of these were complicated procedures that require complex intervention e.g. child delivery. According to the older people, all the mentioned ailments in all four focus groups were managed at home and that was due to utilization of the available resources. The researcher had noticed that there were those ailments that were common to all the four focus groups.

Information in Table 6 illustrates the minor ailments that were common to all the four focus groups.

Table 6 Common minor health ailments in all the four focus groups.

Xhosa version	English version
1. Ukhohlokhohlo *	Colds and Flu
2. Ihlaba	Chest pain
3. Iindlebe ezibuhlungu*	Earaches

4. Intloko ebuhlungu*	Headaches
5. Uqwilikana	Mumps

* shows that 27% of the common minor ailments that were mentioned by all focus are similar to the minor health ailments with other minor health ailments mentioned in conventional medicine list.

Three of these common ailments mentioned fall in the category of minor ailments. Therefore three of the five common ailments (60 %) from all focus groups are similar to the list of conventional minor health ailments.

Table 7 illustrates the ailments that the researcher as well as conventional medicine catalogue does not classify under minor health ailments but the older people in different groups have categorized as minor health ailments.

Table 7 Health ailments that could be consider as major ailments.

Noxolo	Masiphumelele	Mzamomhle	Masithandane
Focus group 1	Focus group 2	Focus group 3	Focus group 4
Ukubeleka Child delivery	Ukuxhuzula Epilepsy	Umqolo Obuhlungu Backache	Isifuba esivalekileyo Asthma
Isinqe Low back pain	Umgqwaliso Face allergy	Ukutsha Burns	Ukubeleka Child delivery
i-Drop Male STD	Ukophuka Fracture	Ukophuka Fracture	Ukuxhuzula Epilepsy
Isiluma Menstruation pains	Imasisi Measles	i-Drop Male STD	Imasisi Measles
Umiselo Infertility	Inkaba Navel extension	Isinqe Low back pain	Isiluma Menstruation pains
Ishimnca New born rash	Ishimnca New born rash	Imasisi Measles	Unkonkonko Tuberculosis
Ingxuluba	Ukukhulelwa	Ukukruneka	

Post delivery pains	Pregnancy	Muscle sprain	
Igcushuwa Syphilis	Amafufunyana Schizophrenia	Igcushuwa Syphilis	
	Igcushuwa Syphilis Amafufunyana Schizophrenia		
	Ukugongqoka kwefokotho Suppressed fontanel		
	Unkonkonko Tuberculosis		

Table 7 showed that some of the minor health ailments mentioned by older people as minor health ailments are not necessarily so. According to Western medicine these were categorized as complicated illnesses that some of them require operations in order to stabilize the condition. Some of these conditions are complicated orthopedic problems that require specialized persons to manage it, for instance back pain, low back pain, and mental health problems, such as Schizophrenia. Some health problems require intensive investigation prior making final decision such as infertility. All these are complex problems that may require more than one person or a specialist to manage it. Some of the minor health ailments that were mentioned by older people do not fall in any of the above categories. Some of them have short life span and some may be managed within a few days.

Table 8 is a list of all the ailments that did not fall in the category of minor or other health ailments.

Table 8 Other health ailments that were considered as either minor or major by the researcher.

Noxolo	Masiphumelele	Mzamomhle	Masithandane
--------	---------------	-----------	--------------

Focus group 1	Focus group 2	Focus group 3	Focus group 4
Ithumba Boil	Ukuqhineka Constipation	Ithumba Abscess	Umqala obuhlungu Sore throat
Ubushushu Elevated temperature	Inyongo Excessive bile	Ukukhothelwa ngumlambo Allergy	Isifesane/Ilido Finger abscess
Umoya omdaka Evil spirit	Ubushushu Elevated temperature	Ubushushu Elevated temperature	Ithumba Abscess
Ukudumba Oedema	Imvume Eye infection	Imvume Eye infection	Ukudumba Oedema
Isisu esibuhlungu Stomach ache	Umgqwaliso Face allergy	Iduma Head haematoma	Izilonda Wounds
Izinyo elibuhlungu Toothache	Isisu esihambisayo Running stomach	Imbilaphu Lymph node swelling	Imvume Eye infection
Umqala obuhlungu Sore throat	Umqala obuhlungu Sore throat	Ukukruneka Muscle Sprain	
Izilonda Wounds	Isisu esibuhlungu Stomach ache	Ukumongoza Nose bleed	
		Iinyawo eziqaqambayo Sore feet	
		Isisu esibuhlungu Stomach ache	
		Izinyo elibuhlungu Toothache	

Table 9 showed some of the ailments that were not classified as minor nor complicated ailments. Some of these ailments are common to the three focus groups and some of these are mentioned by only in one focus group.

4.2.2 Discussion of objective 2:

According to the older people who were participants in the study there were no minor and major ailments during their time. One of the participants said, “In our time, there was nothing like minor and major ailment, we use to manage all the ailments at home.” Another participant affirmed this by saying, “That is very true because at our time, there were no nearby hospitals, so we had no choice but to contain everything within home setting.” Whatever they were managing at home, to them those were minor ailments. Data from these focus groups might be needed for the health professionals to learn more about strategies that older people used successfully.

The older people did have some specialized knowledge that they utilized for the management of some of these ailments. The other ailment that older people classified as minor health ailment is mental health problem such as Schizophrenia. Home-based treatment may also be selected because of the cultural connotation related to this for instance bewitchment. Older people used to refer this condition to the traditional healers for management. Some health problems require intensive investigation prior to making final decision such as infertility. Older people were managing that condition without outside resources.

Though there were some ailments that are similar, some of the minor health ailments that were mentioned by older people are different from those classified by western medicine. According to older people, all these ailments that they mentioned as minor health ailments were manageable in their time. They did not have enough choices to categorize ailments as minor or major because of limited health resources. The challenge that is posed to both Western medicine and people that hold indigenous knowledge is that both of them require learning more about the different strategies used by each other in managing illnesses, so that they find common ground. Older people justify their classification of minor health ailments as lack of resources that means that they used any thing available to manage these ailments. Some of the factors that older people has

outlined, make them still categorize these ailments as minor. This question challenges the existing health system: Is the lack of resources still a problem?

Western medicine develops each day and that is due to the official status that it has in South African health system (Denhill *et al*, 1999). Research for HIV and Aids has been the most financed each year. Whilst the indigenous methods that were used by older people has not been given a chance to develop because of its unofficial status. Therefore mutual learning of western medicine and indigenous might be imperative.

4.3 Objective 3: To determine methods and strategies of using home-based medicine in the management of each of these minor health illnesses.

4.3.1 Data collected from the four senior citizen centre in respect of the management of minor health ailments by older people.

The following data on home based management approaches from older people was collected from all four senior citizen centers namely Noxolo Senior Citizen Centre (Table 10), Masiphumele Senior Citizen Centre (Table 11), Mzamomhle Senior Citizen Centre (Table 12) and Masithandane Senior Citizen Centre (Table 13). When older people were answering this question, they discussed it first, and then reached a consensus to answer the question collectively. According to Xhosa tradition, there is no individual idea or ideas, older people believe in collective ideology. They first discuss an issue, validate it through discussion and accept it as a collective answer (Mtyaphi, 2001). Females were dominating the discussion throughout and the males were just affirming and sometimes had no clue of some of the herbs. This may be due to the fact that women played a key role in house-hold activities. In all the focus groups the ratio of female to male was different. On average the ration of males to females was 2:3, therefore 66% of participants were females and 34% males. The data from each senior citizen centre will be presented separately and a brief discussion will follow each table. The researcher has written the management methods in English. To avoid making this document too bulky, only one raw data of Masithandandane senior citizen centre had been presented in this study in Appendix H in page 103. The researcher has listed the English version of all four focus groups in the following tables.

Table 10 below illustrates the data, which was collected at the Noxolo Senior Citizen Centre.

Table 10 Home remedies that were used by older people of Noxolo and method of administration of those remedies.

Minor ailment	Home-based medicine	Method of administration
1. Ukhohlokhohlo (Colds and Flu)	Mhlonyane (Artemisia Afra)	Boil it with hot water, cool it then drink an amount of tablespoon morning and evening
	Qwili	Boil it with hot water, cool it, and
	(Alepidea Amatymbica)	Then drink one spoon 3 times a day.
	Buvumba (Withania Somnifera)	Crush it into cold water, and then let it be strong. Drink 1 spoon 3 times a day.
	Gangashane	Mix it in cold water overnight, then purge with it in the morning.
2. Ithumba (Boil)	Tolofiya (Prickly pear)	Warm it first, then put some sugar on the lump then put it on the lump
	Mhlabawuvuthwa (Datura Stramonium)	Warm the leaves put it on the lump till it burst.
	i-Swekile ne-Sepha eluhlaza (Sugar and Sunlight soap)	Mix the two, then warm these, then put these on the affected area
3. Uqwilikana (Mumps)	Akukho chiza lisetyenziswayo (No medicine required)	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle's". Then go back home.

4. Isisu esibuhlungu (Stomach aches)	Ngcelwane	Put it in cold water, let it be strong, and then drink 2 spoon of the solution.
	Qwili (Alepidea Amatymbica)	Take a piece, chew it, and then swallow the saliva.
	Mnonono	Crush the leaves into cold water, let it be strong, the drink 1 spoon 3 times a day.
	Sipha	Crush it into powder form, and then swallow it.
	Ntlungunyeba	Crush the leaves, and then put it on the nose for the person to sneeze.
4. Intloko ebuhlungu (Headaches)	Irhonya (An old rag)	Burn it, inhale smoke from it
	Iqhiya emnyama (Black fabric material)	Burn it, inhale smoke from it
	Mhlabawuvuthwa (Datura Stramonium)	Put leaves on the head, and then tighten your head with cloth.
5. Ukudumba (Oedema)	Jongilanga	Warm leaves in warm water, then sooth the affected area.
	Sidikidiki	Tie leaves on the affected area for a certain period, and then take off.
	Mhlabawuvuthwa (Datura Stramonium)	Put the leaves in warm water, then sooth the affected area.
6. Izinyo eliqaqambayo (Toothaches)	Mthuma (Bitter apple)	Open the fruit, and then pour the inside liquid on the aching tooth.
	Jongilanga	Boil the roots, crush it into powder form, then put it on the affected tooth

7. Umkhondo (Evil spirits)	Tswelane (Wild onion)	Take bulb of it, crush them, boil it with water, cool it, then take 1 spoon 3 times a day
	Konofile (Ruta Graveolens) & Vendreti	Mix both of these, crush them, put the mixture in cold water then let it be strong, drink it, 1 spoon 3 times day
	Isicakathi (Agapanthus Africanus)	Put the leaves in cold water, let it strengthen, and then drink it, 1 spoon 3 times a day.
8. Ubushushu High temperature	Tswelane (Wild onion)	Put the bulb in cold water, and then syringe a child by using horn (anally).
9. Ishimnca (Newborn rash)	U-Mthombothi I-Sikrweqa	Take a bark, rub against an object and put some water, then smear it on the affected area, take the other and drink it.
	Umcham'emfene	Let the child drink the mixture of dasiepis.
10. Umqala obuhlungu (Sore throat)	U-Nozinxetyana (Aster Bakerranus)	Soak the leaves in water, gaggle with that mixture in the morning and evening.
	Iingqatha zehagu (Pig's Faeces)	Put pig droppings in water, then gaggle with it morning and evening.
11. Igcushuwa (Syphilis)	U-Sibabile Isepha eluhlaza (Sunlight soap) Ingcelwane	Wash the affected area daily using any of these items i.e. Sibabile, sunlight or ingcelwane.
12. Ingxuluba (Menstruation pains)	Idolo lenkonyane	Boil the leaves in hot water, cool it, and then drink it, ½ cup 2 times a day.
13. i-drop (Male STD)	U-Jongilanga No- bisi (milk)	Mix both and let the ill person drink it, half cup in the morning.
14. Ukubeleka (Child delivery)	Umgcantsi (Horse's post delivery)	Soak the horse's post delivery residues in water, drink it or soak the

	residues) Iintanga zethanga (Pumpkin's seeds)	pumpkin's seeds in water, then drink it. Measurement is half a cup for both solutions in the morning.
15. Izilonda (Wounds)	U-Sibabile Itela endala (Used car oil)	Soak the leaves of the sibabile in water then smear it on the wound. Smear used oil on the wound.
16. Umiselo (Infertility)	Amaqanda kanonkala (Crab's eggs) Iimbaza (Mussels) Unokrwece	Both male and female need to eat all these items as raw as they are. After that they will be fertile and ready to make a child.
17. Imasisi (Measles)	Iingqatha zebhokwe (Goat droppings)	Mix the item with water, drink it half a cup three times a day and some of it smear it on the body.

Table 10 showed that the older people were using different methods for the managing minor health ailments. In this focus group, herbs were used, natural resources such as goat droppings and crab's eggs were used, and in certain case the belief system (see treatment method of mumps on pg 55). When older people were discussing measurements, there was no consistency. Some were saying one teaspoon, others half a cup. When the researcher enquired about this inconsistency, the older people said that a herb does not give problems, even if the person had too much or too little it does not cause any harm. Older people from this focus group were excited about their methods of managing minor health ailments.

Table 11 below illustrates the data that was collected Masiphumelele Senior Citizen Centre.

Table 11 Home remedies that were used by older people of Masiphumelele and method of administration of those remedies.

Minor ailment	Home-based medicine	Method of application
---------------	------------------------	-----------------------

1. Ukhohlokhohlo (Coughing)	Iqwili (Alepidea Amatymbica)	Boil the roots in hot water and put some salt on it. Cool it, and drink half a cup morning and evening.
	Umhlonyane (Aertemisia Afra)	Take its leaves, put it in hot water, soak it, and later drink it half a cup morning and evening.
	I-gamtriya (Gum tree)	Mix the leaves of Gum tree with Aertemisia Afra solution; drink it half a cup morning and evening.
2. Imasisi (Measles)	Iingqatha zebhokwe (Goat droppings)	Mix the item with water, drink it then smear some on the body.
	Umhlonyane (Aertemisia Afra)	Take leaves, mix it with goat dropping solution, drink it and smear some on the body.
	Ubisi lwebhokwe (Goat's milk)	Drink a cup of milk directly from the goat, and then put the sick in dark place.
3. Igcushuwa (Syphilis)	Inkamasana	Boil the leaves in hot water, cool it, and later wash with it.
4. Isisu esilumayo (Stomach- ache)	Uthuvane	Mix the leaves with warm water, drink it and purge with it out.
	Ikhala (Cape Aloe)	Cut the leaves, soak it water, and drink a spoonful of the solution.
	Itshongwe (Bitter wortel)	Dry the bark, crush it, put half spoon and mix it with water, drink a spoon. Or take a piece of the bark, chew it and swallow saliva.
5. Isisu esihambisayo (Diarrhoea)	Umabophe (Plumbago)	Crush the leaves, put it in luke warm water, and drink half a cup twice a day.
	Umnga (Sweet thorn)	Soak the bark in water and later drink the cup when necessary.

	Utswelane (Wild onion)	Boil the bulb, cool it and drink a spoon twice a day.
	Ipesika (Peach leaves)	Crush the leaves, soak it in cold water, and later drink half a cup three times a day.
	Ujwabisile	Choose the red one, cook the bark, and cool it and later drink half a cup morning and evening.
6.Umqala obuhlungu (Sore throat)	uNomacumcumana	Boil the fruit in hot water; cool it, and gaggle with it morning and evening.
	iGangashane	Crush leaves, boil it, and cool it and later gaggle with it.
	iGcukunya	Chew the leaves and swallow the saliva.
	iTswele lomlambo (River onion) iPepile (Pepper)	Make solution of any of these two herbs and gaggle with it morning and evening.
7.Intloko ebuhlungu (Headache)	Itshongwe	Crush the dry leaves into powder form, put it on nose and sneeze it out.
	Irhonya lengxowa (Old sack rag)	Burn it, inhale its smoke and rest .
	uMbezo	Crush the dry leaves, burn it, smoke it and rest.
	Ulwathile	Crush the dry leaves into powder form, put it on nose and sneeze it out.
	Uthuvane	Crush the leaves, pour it on hot water and drink it. It regulates bile which sometimes is a causal factor.
	Ikhamanga	Crush the bark into powder form, put little water in it and put it on the nose.
8. Inkaba (Navel)	uSkhiki (Creeping sage)	Cook the leaves in hot water, cool it and smear the solution on the navel.

extension)	udaka lukanonkala (Crab's mud)	Smear this mud on the navel.
	Uthuthu lwenqawa (Tobacco's ash)	Mix the ash with mother's milk and smear it on the navel.
	Iingqatha zempuku (Mouse's droppings)	Mix the droppings with old wooden ash and mother's milk and put it on the navel.
9. Ubushushu (Elevated temperature)	iGamtriya (Gum tree) Pepatri (Pepper tree)	Take leaves of both Gum tree and Peppertree and rap it around the child.
	uSkhiki (Creeping sage)	Cook the leaves, cool it and syringe it
	Ithongazana	Make a solution with the bark and let the child drink it.
10. Ukubekisa (Child delivery)	Umle (Smoke residue)	A solution is made out of it, drink it and later blow an empty bottle.
	uSkhiki	Burn the leaves, let her inhale the smoke, it ease anxiety.
11. Ihlaba (Chestpain)	Umkhwenkwe Imfingwana	Grate the barks of both of these and make a concoction and let her drink half a cup when necessary.
	Iitsiba zencanda (Porcupine's feather)	Just prick the affected are with the feather.
12. Ukuqhineka (Constipation)	Iingambu zenkuzana	Make a solution with the roots, and then let the child drink it.
	uSkhiki (Creeping sage) nesepha eluhlaza (Sunlight)	Mix the leaves of creeping sage with sunlight, insert it on the anus

13. Iindlebe ezibhobhozayo (Ear discharge)	uSkhiki (Creeping sage)	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	iKonofile	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	uJongilanga	Crush the leaves, soak in water, pour it on the ears and close it with wool.
	Inyongo yehagu (Pig's bile)	Just pour few drops on the ear
	umchamo wokuqala (Morning's first urine)	Just pour few drops on the ear
	Amagqabi epesika (Peach leaves)	Put the leaves in warm water, and pour few drops on ears.
14. Amehlo imvume (Eye infection)	Ubisi lwebele (Mother's milk)	Put some drops on the eye
15. Unkonkonko (Tuberculosis)	Isitixo esidala (Old key) Ipeni endala (old coin)	Make a necklace with any of these and let the sick wear it around neck.
	Ubisi lwedonki (Donkey's milk)	Drink the donkey milk half a cup morning and evening.
	Unonkala (Crab)	Cook the crab, let the sick person drink its gravy
16. Ishimnea (Newborn rash)	uMthombothi	Rub any of these two herbs on a flat stone and mix with water and smear on face.
	Umchamo wemfene	
	Ubulongwe bencamazana	Mix it with mother's milk and smear it on the face.
17. Ukophuka (Fracture)	Umhlabelo omhlophe	Crush the bark I powder form, make a solution and drink it.

	Umathunga	Soak it in warm water, and cleanse the affected area.
	Umnga	Tie the bark around the affected area and put two planks around the fracture.
18. Umqwaliso (Face allergy)	Uvuthuza Ilabatheka	Put the leaves of any of these two into warm water and steam with it.
	Ufudo Isiqodi Inqwebaba	Make a solution of all the three items, drink it, wash with it, steam with it and purge with it.
	Imbosiso	Put the leaves in warm water, steam and purge with it.
	Inywibiba (Arum lily)	Make a solution with the flower, purge with it, steam with it and wash with it.
19. Ukuxhuzula (Epilepsy)	Umvumvu Mgqomagqoma	Make a solution with leaves and let the sick drink a cup twice a day.
	Inqwebaba neRabiya	Dry the leaves, put it on nose and sneeze it out.
20. Inyongo (Excessive bile)	Umnquma (Wild Olive)	Take leaves, soak in warm water and purge with it.
	Inkuphulana	Take leaves, soak in warm water and purge with it.
	Uthuvane	Take leaves, soak in warm water and purge with it.
	uGobeleliweni	Crush the stem and roots, make a solution and drink it.
	uMsenge	Crush leaves, boil it, cool it, and later drink it
21. Ukugongqoka kwefokotho (Suppressed fontanel)	Isivimbampunzi Ikonofile	Crush the bulb and later make solution, pour it on all openings i.e. nose and anus.

22. Uqwilikana (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, “Mumps get out of me, go to people with cattle”. Then the person would go back home
---------------------------	-------------	---

Table 11 showed that this focus group had 22 minor health ailments and different strategies of managing them. These also included herbs, belief models and as well as usage of natural resources. There are some commonalities with the methods of management with the focus group 1 (Noxolo), i.e. management of mumps being a belief of going to the open field and cough it on an isolated hole. The volume of herb consumption was also inconsistent with this group. The preparation of herbs was in different forms in this focus group, such as oral medication, purgatives, inhalants and bathing. The following focus had also gender balance and all participants were contributing actively.

Table 12 below illustrates the data which was collected at Mzamomhle Senior Citizen Centre.

Table 12 Home remedies that were used by older people of Mzamomhle and method of administration of those remedies.

Minor ailment	Home based medicine	Method of application
1. Isisu esibuhlungu (Stomach ache)	Ikhala (Cape aloe)	Crush it, put it in water and drink it.
	Ulwathile	Dry it, crush it and inhale till you sneeze.
2. Intloko eqaqambayo (Headache)	Irhonya elidala Iqhiya emnyama	Take any of these, burn it and inhale the smoke.
	Itshongwe (Bitter wortel)	Dig it, dry it, and crush it into powder form and sneeze with it.
	Ulwathile	Crush it, soak in water, and pour it on the nose.

3. Ubushushu bomntwana (Elevated temperature)	Isivimbampunzi Ikonofile	Take any of these, put the leaves in warm water, syringe it at the back or wash the child with it.
4. Ukhohlokhohlo (Coughing)	Umhlonyane (AertemisiaAfra) Iqwili (Alepidea Amatymbica) negamtriya (Gumtree)	Make a mixture of any of these, drink it or just chew gum tree leaves and swallow saliva
5. Ukukhothelwa ngumntwana (Allergy)	Umsola	Crush it and make mixture with water, drink it and smear some left.
	Ingubo yesele (Algae)	Smear it on the face.
6. Indlebe ebuhlungu (Ear ache)	Inyongo yehagu (Pig's bile)	Pour it on the sore ear/s
	Usikhotha	Crush leaves, put on fabric, soak in water and pour drops on ear/s
7. Amehlo abuhlungu (Eye ache)	Ubuthuvi benyanga	Crush the roots into powder form; put it inside the affected eye.
8. Inyawo eziqaqambayo (Sore feet)	Uqaqqa (Weeds)	Take it with roots, soak it in water and put both feet. Let the feet dry up.
9. Ukophuka (Fracture)	Umnga (Sweet thorn)	Tie the bark around the affected area.
	Umathunga	Soak the leaves in warm water, and cleanse the affected area. Drink some of it.

10. Igcushuwa (Syphilis) 11. i-drop (Male STD)	Unknown	One participant remembered that syphilis was managed but did not remember the herb. Other did not know.
	Umthuma (Bitter apple)	Cut the fruit, soak it in warm water and syringe at anus.
12. Umqolo obuhlungu (Back ache)	Umthuma (Bitter apple)	Cut it, soak it in warm water and syringe it on the buttocks
	Umkwenkwe Uchithibhunga	Make a solution of these two plants (leaves) in water and drink half a cup twice a day
13. Isinqe esibuhlungu (Low back pain)	Umthuma (Bitter apple)	Cut the fruit, soak it in warm water and syringe it on the anus
14. Ithumba (Boil)	Umhlabawuvuthwa (Datura Stramonium)	Put the leaves on warm subject, when warm put it on affected area.
	Iswekile (Sugar)	Put bit water on the sugar and put it on the affected area.
15. Imasisi (Measles)	Iingqatha zebhokwe (Goat's droppings)	Mix the item with water, drink it then smear some on the body.
	Ituwa yenkukhu (Chicken droppings)	Make solution with water, drink it and smear some of it on the body.
16. Ukukruneka (Muscle sprain)	Umhlabawuvuthwa (Datura Stramonium)	Tie the leaves on the affected area.
17. Ukutsha (Burns)	Amanzi (Water)	Soak the burnt area in cold water.
	Umthubi weqanda (Egg yoke)	Put egg yoke on the affected area

	Umnga (Sweet thorn)	Burn the bark, take its charcoal and smear it on the affected area.
18. Iduma (Head haematoma)	Igangashana	Dry the leaves, crush it and put it on affected area.
19. Ihlaba (Chest pain)	Umwelela	Chew the leaves and later the pain will vanish.
	Inaliti (Needle)	Pinch the affected area, later it will be better.
20. Imbilaphu (Abscess)	Ikhala (Aloe)	Cut the leaf, warm it and tie it around the abscess.
21. Uqwilikana (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle". Then go back home
22. Izinyo elibuhlungu (Tooth ache)	Umthathi	Burn the leaves, let smoke pass the sore teeth, worm that cause soreness will come out.
23. Ukumongoza (Nose bleed)	Amanzi abandayo (Cold water)	Soak cloth in cold water and put it on the forehead.

Table 12 showed that there were different methods of administration that used by this focus group, i.e. inhalants, anal insertions, drinks and belief system. In terms of inhalants, older people in this group were crushing dried leaves of Bitter wortel to be inhaled it then sneezed out. This method was helping with the healing of headache. For anal insertions, older people were crushing Bitter apple and made solutions, then inserted it on the buttocks for management of backache. Mumps was also managed through belief system. All the participants in this group actively participated. There were methods that were similar to other groups that were mentioned by this group such as inhalants for headaches.

Table 13 below illustrates the data which was collected at Masithandane senior citizen centre.

Table 13 Home remedies that were used by older people of Masithandane and method of administration of those remedies.

Minor ailment	Home-based medicine	Method of application
1.Intloko eqaqambayo (Headache)	Iqhiya emnyama (Black fabric) Irhonya (Rag)	Take any of these, burn it and inhale the smoke.
	Itshongwe	Dig it, dry it, crush it into powder form and sneeze with it.
2. Ukhohlokhohlo (Coughing)	Iqwili (Alepeidea) Amatymbica)	Boil it hot water and put some salt on it. Cool it, and drink it
	Umhlonyane (Aertemisia Afra)	
	Ubushwa	Take its leaves, put it in hot water, soak it, and later drink it.
	Igamtriya (Gum tree)	Mix the leaves it with Aertemisia Afra solution, then drink it.
3. Indlebe ezibuhlungu (Ear ache)	Iphewula	Cut it, squeeze liquid out, pour it on the ear/s.
	Amafutha enja 'selwandle (Seal's oil)	Pour drops on the affected ear/s.
	Amafutha enkukhu (Chicken's Oil)	Pour drops on the affected ear/s.
4.Umqala obuhlungu (Sore throat)	Igangashane	Make solution and gargle with it.
	Uzifozonke (Potassium permanganate)	Make solution and gargle with it.
5.Isifuba	Isivimbampunzi	Make solution using it bulb, cook it,

esibuhlungu (Chest pain)	(Garlic)	cool it and later drink it.
6. Isifuba Esivalekileyo (Tight chest)	Umhlonyane (Aertemisia Afra)	Make solution, cook it, cool it and drink it.
	Amafutha enja 'selwandle	Drink this one as raw as it is.
7. Ilido/Isifesane (Finger abscess)	Igangashane	Warm the leaves put it on the affected area.
	Iswekile nesepha eluhlaza (Sugar and Sunlight soap)	Mix the two stems and put these on the affected area.
8. Irhashalala (Measles)	Iingqatha zebhokwe	Mix the goat droppings with water, drink it then smear some on the body.
9. Ithumba (Boil)	Ivumbango	Cut the leaf, warm it and put it on the affected area.
	Ikhala (Cape aloe)	Cut the leaf, warm it and put it on the affected area. Tie it with cloth.
10. Uqwilikane (Mumps)	No medicine	Wake up in the morning, go to the bush, look for an isolated hole, and cough on it and say, "Mumps get out of me, go to people with cattle's". Then go back home
11. Unkonkonko (Tuberculosis)	Ubisi lwedonki/hashe (Donkey/Horse' milk)	Drink a spoon of any of these, three times a day.
12. Ukudumba (Oedema)	Umhlabangulo	Boil it in hot water, cleanse the affected area.
	Iphewula	Cut it, tie it on the affected area
	Umhlonyane (Aertemisia Afra) nobushwa	Make a solution, drink it.
13. Ukuxhuzula (Epilepsy)	Ilaphu elidala (Old rag)	Burn it, let him/her inhale smoke.
	Uthuvane	Make solution-using leaves, let the client drink it.
14. Izilonda	Amafutha ehagu	Mix the Pig's fat with the leaves of the

(Wounds)	(Pig's fat) Usibabile	Sibabile, and then smear on the wound
15. Imvuma (Eye infection)	Ubisi lwebele (Mother's milk)	Pour drops of mother's milk on the eyes.
16. Ihlaba (Chest pain)	Uzifozoneke (Potassium pemananganete) Umchamo wemfene	Make solution, and then drink it. Crush it, make solution, and then drink it.
17. Ukubeleka (Child delivery)	Umchamo wemfene	Make a solution then drink it. It soothes the pain. Sleep on one side and the midwife will do the rest.
18. Isisu esilumayo (Stomach ache)	Ukrakrayo Uzifozoneke (Potassium pemananganete)	Make solution of any of the two, drink it
	Itshongwe	Cook the leaves in hot water, cool it and later drink it.

Table 13 showed that this group had 18 ailments mentioned and various strategies used for treatment. Treatment strategies used by older people in this group are similar to other group. The participants in this group were dominated by women.

The researcher will illustrate the treatment approaches used and methods of administration for each focus group. These treatment approaches and methods of administration will be aligned with minor health ailment mentioned and the type of herb used for this ailment. Refer to point 4.3 of objective 3 for the details of preparation.

Table 14 shows treatment approaches and method of administration of Noxolo senior citizen centre.

Oral method of administration (by mouth)

Minor health ailments	Home based medicine	Treatment approach
Ukhohlokhohlo (Coughing)	Umhlonyane (Artemisia Afra)	Mixture
	Iqwili (Alepidea Amatymbica)	Mixture

	Ubuumba (Withania Somnifera)	Mixture
	Gangashane (Not known)	Mixture
Isisu esibuhlungu (Stomach ache)	Ngcelwane (Unknown)	Mixture
Umkhondo (Evils spirit)	uTswelane (Wild onion)	Mixture
	i-Konofile (Ruta Graveolens) & i-Vendreti	Mixture
	Isicakathi (Agapanthus Africanus)	Mixture
Isicakathi (Newborn rash)	Umthomboti	Mixture
	Umcham' emfene	Mixture
Umqala obuhlungu (Sore throat)	uNozinxetyana (Aster Bakerrranus)	Mixture
Isiluma (Menstruation pains)	Idolo lenkonyane	Mixture
i-Drop (Male STD)	uJongilanga nobisi (Sunflower and milk)	Mixture
Ukubeleka (Child delivery)	Umngcantsi (Horse's post delivery residue)	Mixture
Imasisi (Measles)	Iingqatha zebhokwe (Goat droppings)	Mixture and Lotion
Umiselo (Infertility)	Amaqanda kanonkala (Crab's eggs)	Extracts
Sublingual method of administration (under the tongue)		
Minor health ailment	Home based medicine	Treatment approach
Isisu esibuhlungu (Stomach ache)	Iqwili (Alepidea Amatymbica)	Extract
Topical method of administration (through the skin)		
Minor health ailment	Home based medicine	Treatment approach

Ithumba (Boil)	Itofofiya (Prickly pear)	Extract
	Mhlabawuvuthwa (Datura stramonium)	Extract
	Iswekile nesepha eluhlaza (Sugar and sunlight)	Extract
Intloko ebuhlungu (Head aches)	Mhlabawuvuthwa Datura stramonium	Extract
Ukudumba (Edema)	Ujongilanga (Sunflower)	Liniments
	Sidikidiki	Extract
	Mhlabawuvuthwa (Datura stramonium)	Extract
Izinyo eliqaqambayo (Tooth ache)	Umthuma (Bitter apple)	Extract
Ishimnca (Newborn rash)	Umthombothi	Lotion
Isilonda (Wound)	uSibabile	Extract
Bathing method of administration (affected body part)		
Minor health ailment	Home based medicine	Treatment approach
Igcushuwa (Syphilis)	Idolo lenkonyane	Extract

Table 14 showed that minor health ailments of Noxolo Senior Citizen Centre were treated using oral, sublingual, and topical and bathing methods of administering their home based medicine.

The following table 15 illustrates approaches and methods that were mentioned by Masiphumelele.

Table 15 Treatment approaches and method of administration of Masiphumelele senior citizen centre.

Oral method of administration

Minor health ailments	Home based medicine	Treatment approach
Ukhohlokhohlo (Coughing)	Iqwili (Alepidea Amatymbica) Umhlonyane (Artemisia Afra) i-Gamtriya (Gum tree)	Mixture
Imasisi (Measles)	Iingqatha zebhokwe (Goat droppings) Umhlonyane (Artemisia Afra) Ubisi lwebhokwe (Goat's milk)	Mixture
Isisu esibuhlungu (Stomach ache)	u-Thuvane Ikhala (Cape Aloe) Itshongwe (Bitter wortel)	Mixture
Isisu esihambisayo (Diarrhea)	Umabophe (Plumbago) Umnga (Sweet thorn) Utswelane (Wild onion) Amagqabi epesika (Peach leaves) u-Jwabisile	Mixture
Umqala obuhlungu (Sore throat)	u-Nomacumcumana i-Gangashane i-Gcukunya Ittswele lomlambo	Mixture

	(River onion) ipepile (Pepper)	
Ubushushu (Elevated temperature)	Igamtriya (Gum tree) ipepatri (Pepper tree) i-Thongazana	Mixture Mixture
Ukubeleka (Child delivery)	Umle (Smoke residue)	Mixture
Ihlaba (Chest pain)	u-Mkhwekhwe i-Mfingwana	Mixture
Ukuqhineka (Constipation)	Iingcambu zenkuzana	Mixture
Unkonkonko (Tuberculosis)	Ubisi lwedonki (Donkey's milk) Unonkala (Crab)	Mixture
Ukophuka (Fracture)	Umhlabelo Umathunga (eucomis autumnalis)	Mixture
Ishimnca (New born rash)	Umthombothi	Mixture
Ukuxhuzula (Epilepsy)	Umvumvu Umgqomagqoma	Mixture
Inyongo (Excessive bile)	Umnquma (Wild olive) Inkuphulana Uthuvane Ugobeleliweni Umsenge	Mixture
Topical method of administration		
Minor health ailment	Home based medicine	Treatment approach

Imasisi (Measles)	Iingqatha zebhokwe (Goat's droppings)	Lotion	
	Umhlonyane (Artemisia Afra)	Lotion	
Inkaba (Navel extension)	Uskhiki (Creeping sage)	Lotion	
	Udaka lukanonkala (Crab's mud)	Lotion	
	Uthuthu lwenqawe (Tobacco's ash)	Lotion	
	Ituwa yempuku (Mouse droppings)	Lotion	
Ubushushu (Elevated temperature)	Igamtriya (Gum tree)	Extract	
	Ipepatri (Pepper tree)	Extract	
Ihlaba (Chest pain)	Iintsiba zencanda (Porcupine feathers)	Extract	
Iindlebe ezibhobhozayo (Ear discharge)	Uskhiki (Creeping sage)	Lotion	
	-Konofile (Ruta Graveolens)	Lotion	
	Jongilanga (Sunflower)	Lotion	
	Inyongo yehagu (Pig's bile)	Lotion	
	Umchamo wokuqala (Early morning urine)	Lotion	
	Amagqabi epesika (Peach leaves)	Lotion	
	Imvuma (Eye infection)	Ubisi lwebele Mother's milk	Lotion
	Unkonkonko	Isitixo esidala	As it is

(Tuberculosis)	(Old key) Ipeni endala (Old coin)	
Ishimnca (New born rash)	Umthombothi Umchamo wemfene Ubulongwe bencamazana	Lotion Lotion Lotion
Ukophuka (Fracture)	Umathunga (eucomis autumnalis) Umnga (Sweet thorn)	Liniment Extract
Ukugongqoka kwefokotho (Suppressed fontanel)	Isivimbampunzi i-Konofile (Ruta Graveolens)	Lotion
Bath method of administration		
Minor health ailment	Home based medicine	Treatment approach
Igcushuwa (Syphilis)	Inkamasana	Liniment
Umgqwaliso (Face allergy)	Ufudo-inqwebeba-isiqodi	Liniment
Steaming method of administration		
Minor health ailment	Home based medicine	Treatment approach
Umgqwaliso (Face allergy)	Uvuthuza Ilabatheka (Dioscorea dregeana) Ufudo-inqwebeba-isiqodi Imbosiso Inywibiba (Arum lily)	Liniments Liniments Liniments Liniments Liniments
Rectally method of administration		
Minor health ailment	Home based medicine	Treatment approach
Ubushushu (Elevated temperature)	Uskhiki (Creeping sage)	Enema
Ukuqhineka	Uskhiki nesepha eluhlaza	Enema

(Constipation)	(Creeping sage and sunlight soap)	
Smoking method of administration		
Minor health ailment	Home based medicine	Treatment approach
Intloko ebuhlungu (Headache)	Itshongwe	Inhalant
	Irhonya (Old sac rag)	Inhalant
	Umbezo	Inhalant
	Ulwathile	Inhalant
	Ingomanga	Inhalant
Ukubeleka (Child delivery)	Uskhiki (Creeping sage)	Inhalant

Table 15 showed that minor health ailments of Masiphumelele Senior Citizen Centre were treated using oral, topical, steaming, rectal and smoking methods of administering their home based medicine.

The following table 15 shows treatment approaches of method of administration of Mzamomhle.

Table 16 Treatment approaches and method of administration of Mzamomhle Senior Citizen Centre.

Oral method of administration		
Minor health ailment	Home based medicine	Treatment approach
Isisu esibuhlungu (Stomach ache)	Ikhala (Cape Aloe)	Mixture
	Ukhohlokhohlo (Coughing)	Mixture
	Iqwili (Alepidea Amatymbica)	Mixture
	Umhlonyane (Artemisia Afra)	Mixture
	iGamtriya (Gum tree)	Mixture
Ukukhothelwa	Umsola	Mixture

ngumntwana (Allergy)		
Ukophuka (Fracture)	Umathunga (eucomis autumnalis)	Mixture
Umqolo obuhlungu (Back ache)	Umkwenkwe Uchithibhunga	Mixture Mixture
Imasisi (Measles)	Iingqatha zebhokwe (Goat's droppings)	Mixture
Ihlaba (Chest pain)	Umwelela	Extract
Smoking method of administration		
Minor health ailment	Home based medicine	Treatment approach
Izinyo eliqaqambayo (Tooth ache)	Umthathi	Inhalant
Rectally method of administration		
Minor health ailment	Home based medicine	Treatment approach
i-Drop (Male STD)	Umthuma (Bitter apple)	Enema
Ubushushu (Elevated temperature)	Isivimbampunzi i-Konofile (Ruta Graveolens)	Enema Enema
Isinqe esibuhlungu (Low back pain)	Umthuma (Bitter apple)	Enema
Umqolo obuhlungu (Back ache)	Umthuma (Bitter apple)	Enema
Topical method of administration		
Minor health ailment	Home based medicine	Treatment approach
Ukukhothelwa ngumntwana (Allergy)	Umsola Ingubo yesele (Algae)	Lotion Extract
Indlebe ebuhlungu (Ear ache)	Inyongo yehagu (Pig's bile) Usikhotha	Lotion Lotion

Amehlo abuhlungu (Eye ache)	Ubuthuvi benyanga	Extract
Iinyawo eziqaqambayo (Sore feet)	Uqaqaqa (Weeds)	Liniment
Ukophuka (Fracture)	Umnga (Sweet thorn) Umathunga (eucomis autumnalis)	Extract Liniments
Ithumba (Boil)	Umhlabawuvuthwa (Datura Stramonium) Iswekile (Sugar)	Extract Lotion
Imasisi (Measle)	Iingqatha zebhokwe (Goat's droppings) Ituwa yenkukhu (Chicken residues)	Liniments Liniments
Ukukruneka (Muscle sprain)	Umhlabawuvuthwa (Datura Stramonium)	Extract
Ukutsha (Burns)	Amanzi abandayo (Cold Water) Umthubi weqanda (Egg yoke) Umnga (Sweet thorn)	Liniment Lotion Lotion
Iduma (Head haematoma)	Igangashane	Liniments
Ihlaba (Chest pain)	Inaliti (Needle)	As it is
Ukumongoza (Nose bleed)	Amanzi abandayo (Cold water)	Lotion
Nasal method of administration		
Minor health ailment	Home based medicine	Treatment approach
Isisu esibuhlungu	Ulwathile	Inhalant

(Stomach ache)		
Intloko ebuhlungu (Head ache)	Irhonya (Old rag) Iqhiya emnyama (Black fabric) Itshongwe (Bitter wortel)	Inhalant Inhalant I nhalant

Table 16 showed that minor health ailments of Mzamomhle Senior Citizen Centre were treated using oral, topical, nasal, rectal and smoking methods of administering their home based medicine.

Table 17 Treatment approaches and method of administration of Masithandane Senior Citizen Centre.

Oral method of administration		
Minor health ailment	Home based medicine	Treatment approach
Ukukhohlela (Coughing)	Iqwili (Alepidea Amatymbica) Umhlonyane (Artemisia Afra) iGamtriya (Gum tree) Ubushwa	Mixture Mixture Mixture Mixture
Umqala obuhlungu (Sore throat)	Igangashane Uzifo zonke (Potassium permanganate)	Mixture Mixture
Ihlaba (Chest pain)	Isivimbampunzi	Mixture
Isifuba esivalekileo (Tight chest)	Umhlonyane (Artemisia Afra) Amafutha enja yselwandle (Seadog's oil)	Mixture Mixture
Imasisi	Iingqatha zebhokwe	Mixture

(Measle)	(Goat's droppings)	
Unkonkonko (Tuberculosis)	Ubisi lwedonki (Donkey milk)	Mixture
Ukudumba (Oedema)	Umhlonyane (Artemisia Afra)	Mixture
Ukuxhuzula (Epilepsy)	Uthuvane	Mixture
Ukubeleka (Child delivery)	Umchamo wemfene	Mixture
Isisu esibuhlungu (Stomach ache)	Ukrakrayo	Mixture
	Uzifozonke (Potassium permanganate)	Mixture
	Itshongwe (Bitter wortel)	Mixture
Topical method of administration		
Minor health ailment	Home based medicine	Treatment approach
Iindlebe ezibuhlungu (Ear ache)	Iphewula	Liniment
Isifesane (Finger abscess)	Igangashane	Liniment
	Iswekile nesepha eluhlaza (Sugar and sunlight soap mixture)	Linctuses
Imasisi (Measles)	Iingqatha zebhokwe (Goat's dropping)	Liniments
Ithumba (Boil)	Ivumbango	Liniments
	Ikhala (Cape Aloe)	Liniments
Ukudumba (Oedema)	Umhlabangulo	Liniments
	Iphewula	Liniments
Izilonda (Wounds)	Amafutha ehagu (Pig's fat)	Liniments
	Usibabile	Liniments
Imvume (Eye infection)	Ibisi lebele (Mother's milk)	Liniments

Nasal method of administration		
Minor health ailment	Home based medicine	Treatment approach
Intloko ebuhlungu (Headache)	Iqhiya emnyama (Black fabric)	Inhalant
	Irhonya (Old rag)	Inhalant

Table 17 showed that minor health ailments of Masithandane Senior Citizen Centre were treated using oral, topical, inhalant, and nasal methods of administering their home based medicine.

4.3.2 Discussion of objective 3:

Each focus group had identified various treatment methods and approaches of managing minor ailments. These management strategies that were used by older people were in different forms namely, plants, objects, waste products, artificial foods, other natural resources and others were based on belief system. Most of these treatment strategies that were used by older people were common in all focus groups.

A diversity of plants were used, some that were planted for medicinal use at home and other plants that were collected from the bushes and mountains. Some plants were prepared while fresh from the soil while other were left to dry, then later used. Any plant has components namely roots, stem, leaves and flowers. All these components were used for various treatment media and the older people were careful in terms of what to use or what not to use in any plant.

The older people were also using various objects as methods of treatments. These were old rags, black fabric (one commonly worn by newly married women), old coin, old key, mouse' droppings, pig's stools and horse's post delivery residues and used car oil. These objects were used to manage various minor health ailments. Older people were confident of their treatment strategies.

In certain instances, older people used various natural resources such as water, crab's mud, tobacco's ashes, mother's milk, pig's bile, pig's fat, egg yoke and seal's fat. These resources were also used for various minor health ailments. There were also some commonalities from one focus group to the other.

Other small component of treatment approach is the use of artificial food such as processed sugar and not sugar cane and also the use of sunlight soap. This may open a debate about the issue of modernizing the indigenous knowledge since both products are products that were invented in the 19th century.

The measurements of the home-based medicine used by older people were varying from a spoonful to half a cup. Older people were not having consistency when administering their herbs. The researcher enquired about the inconsistency and they responded by saying herbs are not harmful. So this means that consumption amount was not an issue. The only thing that older people emphasized about these herbs was that they need to be taken before meals.

All these treatment approaches were in different forms such as enemas (rectal injections), extracts (crude drugs), infusions (crude drugs in water), inhalants (vaporized), linctuses (liquids), liniments (liquid for external application) and lotions (applications on the skin). Their administration was also in different. Some were administered through the mouth (orally), under the tongue (sublingually) and various others.

4.4 Objective 4: To determine when the older person would regard that their strategies were not working and refer to an outside source and to determine which source would they refer to.

All the participants from these four focus groups agreed that their strategies were successful. This means that older people's strategies did not fail in terms of alleviating the illness. All the sick people were healed by the methods and strategies that older people were implementing. Yet, they agreed that there were exceptional cases when some sick people were not getting better. In those cases, older people would refer to various traditional healers available within their surrounding. These traditional healers were traditional doctors, herbalists, and traditional midwives.

Table 18 illustrates the response of the older people about different referral sources.

Table 18 Referral resources of older people when their strategies failed.

Noxolo	Masiphumelele	Mzamomhle	Masithandane
Focus group 1	Focus group 2	Focus group 3	Focus group 4
Diviners	Diviners	Diviners	Diviners
Herbalist	Herbalist	Herbalist	Herbalist
Doctors	Traditional midwives	Traditional Midwives	

Table 18 showed that diviners, herbalists, traditional midwives and doctors were the referral source when older people's strategies failed. The common referral source for all the focus group are the diviners and herbalist. These sources are still a referral source today.

4.4.1 Discussion of objective 4: To determine when would the older person regard that their strategies are not working and refer to an outside source and to determine who would they refer to?

Older people mentioned that referring of a sick person was their last attempt. They trusted their medication but they mentioned that if there was any strange illness or when an illness persisted even if they administer their herbs, they would consult an outside source. Older people mentioned that it was easy for them to know whether an illness required Western medicine intervention or if it required traditional healers. Generally the older people had confidence in their medicine and methods, but there were instances where they needed to consult outside source for instance for the management of schizophrenia. Those who had doctors and hospitals nearby, referred to them. Older people mentioned that for cultural related issues or instances whereby a ritual had to be performed, they would consult diviners (amaqhira) for clarification. In instances where the older people knew the problem but did not know treatment strategy, they would consult herbalist. Visiting of the herbalist was very rare for the older people because they were knowledgeable about the herbs that they were using.

4.5 Comments on findings.

In this chapter the researcher attempted to map out the research findings of the exploration of indigenous health knowledge carried out by older people in the management of minor health ailments in both the Khayelitsha and Phillipi communities. Quantitative and Qualitative methods of data collection were used in both data collection and analysis of the findings. The findings were illustrated in the form of tables and percentages. Each objective was presented separately and discussed thereafter. The list of the minor health ailments mentioned by older people in this study was endless. This might be due to the fact that in their era, all ailments were contained within the home setting. As some of the participants have affirmed that in their time there was no minor or major ailment, therefore all ailments to them were minor. The treatment strategies that they use were simple and favourable for their circumstance, for example, putting mucus on a burned area was good then for the quick drying effect but not for this era. There are some strategies that were used by older people that need to be revised and assessed for them to be suitable for the current era. Certain complicated medical procedures like child delivery are still a private matter to some rural woman and some older people. This activity is seen as simple and private. Some women pursue child delivery by themselves with no assistance. Therefore, western and traditional worlds still requires learning more about each other.

Transference of the indigenous health knowledge from generation to generation was just an oral tradition. One of the older people who participated did not have rural background. He was born in Cape Town but he knew most of the herbs used for managing minor health ailment. He learnt to use these herbs from his father who was born in the Eastern Cape and he has been using these herbs ever since. The indigenous health knowledge system is passed from generation to generation by oral tradition and experiential learning and that information can be passed to the youth of today, who will as older people could pass it to their own children. This knowledge was not passed to the first generations (children of the grandparents), it was commonly passed to the second generation (grandchildren) by the older people. Second generation of today is in peri-urban areas with their working parents who do not have the knowledge that was passed by their parents. Therefore it is imperative for the youth of today to grab this opportunity and utilize the indigenous health knowledge. This will happen when the research outcome has

been validated and the information is made accessible through hospital, school and public libraries.

4.6 Limitations

- The hours that were taken for each of the focus group were lengthy for the older people to concentrate. The older people were tired at the end of each of the focus groups. This might have affected the quality of the results of the study.
- The literature which clearly states the minor health ailments was limited; instead terms like acute illnesses were used. The researcher found it difficult to distinguish the difference between minor and major ailments in modern medicine.
- Some medicinal plants had English and Zulu names, but not Xhosa names. Only a few of the plants names in Xhosa had English translations.
- The fact that the study sample came from senior citizen centres and not the general population.

4.7 Validity

The data collected from older people had various level of validation.

Consensus reaching: - Firstly during the process of data collection, the researcher was reading the questions clearly and repeatedly to ensure that older people understood what was required from them.

Repeatability: - Secondly, older people were discussing a point, and then they would reach a common understanding about the right answer. The research assistants were only writing the final answer from those discussions of the older people. So those discussions that they had were validating the data.

Repeatability: - Thirdly, after having written the whole data, the researcher had went back to the older people and affirm whether what was written is what older people have mentioned. Data collected was compared with the list of modern medicine in order to affirm that list of minor ailments that they mention is not way far from the medically accepted one.

Member checking: - Data was transcribed, after being transcribed; it was taken to a linguist for affirmation.

The key informant has also played important role in validating lifestyle of the Xhosa people and also the names of the herbs. He used his experience of being a traditional healer.

4.8 Summary of chapter 4

In this chapter the researcher described a wide variety of what older people mentioned as minor health ailments, whilst Western medicine listed few minor health ailments. Older people had a broad range of resources within their household that helped them to manage any illnesses, hence to them all ailments were regarded as minor because they were managing them. This has shown that older people need to collaborate with health workers so that both parties can clearly distinguish between minor and major health ailments.

The older people from the four focus groups have used various treatment methods of administration in management of these minor health ailments. There were common approaches and methods of administration in all four focus groups. According to older people their life was not as complicated as it is at moment; they use to do any forms of health management using available resources. Their treatment methods included a variety of resources such as plants, objects, waste products, artificial foods, other natural resources and some were based on their belief system.

Their home-based medicine was administered in different forms such as oral administration, bathing, lotions and various other forms mentioned in the study. This chapter has clearly shown the simple methods that older people used in the management of minor health ailments using available resources. It is also provides for the youth to realize what kind of important information they are neglecting at home.

CHAPTER 5

SUMMARY OF THE STUDY AND RECOMMENDATIONS

Khayelitsha (Site B), Michael Mapongwana, Inzame Zabantu and Mzamomhle Community Health Centres in Khayelitsha and Phillipi are overburden with clients. A certain portion of the clients attending these Community Health Centres (CHC) present with minor health ailments (Keeran *et al*, 2000). When this problem was identified, it was not left as a responsibility of the people who identified it. This problem required the attention of various people. Health workers from Khayelitsha and Phillipi, health educators from University of Cape Town, students from UCT, and communities under the study area and older people who were part of the communities formed a forum that had to address the problem identified.

Discussions within the forum took place and conclusions were reached which identified the need to explore the indigenous health knowledge that is carried by older people for management of minor health ailments. Older people affirmed that their indigenous knowledge might help to solve the problem of overcrowding community health centres. So, the existence of this problem brought forth what older people were capable of as they were the first line managers of health problems.

Social and political changes in South Africa might have impact on suppression of the indigenous knowledge systems. Older people who are carriers of indigenous health knowledge have experienced changes in their roles due to factors such as urbanization and modernization. Some of them had to leave rural setting where they were freely practising their indigenous health knowledge for the management of minor health ailments and had to relocate to peri-urban areas such as Khayelitsha and Phillipi.

While older people who reside in Khayelitsha and Phillipi, their roles of being independent has changed to being dependant. Some of them had to stay with their children or grandchildren, some of them had to be in senior citizen centres and some of them had to be in old age homes. These factors have changed their lifestyle completely because they had to comply with their present setting and environment. Initially older

people were in authority in their rural settings and changing circumstances has made them sub-ordinates.

Politically, the African National Congress led government implemented PHC with the intention of making health services accessible to the previously disadvantaged communities. Community Health Centres at Khayelitsha and Phillipi are overcrowded day by day and this does not serve the initial purpose of making services accessible. According to the PHC principles, community involvement is important in addressing health needs of that particular community. Western medicine has an official status and power whilst traditional medicine remains currently non-official. Western medicine is developing as a result of research funding whilst the indigenous knowledge or traditional medicine is losing its popularity. South Africa can learn from other developing countries such as Brazil, whereby both Western and traditional medicine co-exist as equal partners in addressing the health needs of their country, then both the indigenous and Western medical can co-exist and strengthen the health system.

The researcher who was part of the health forum that discussed the problem of overcrowded CHC's, was interested in exploration of the indigenous health knowledge systems carried by older people. Research initiatives of pursuing this problem were financially supported by the NRF.

Having compared what older people perceived as minor ailments to what western medicine listed, the list is endless. Older people were managing everything in a home setting; hence all ailments are minor to them. Their traditional methods and strategies were interesting and some of these management strategies were common to those of the western medicine. So if both western and traditional medicines can learn from each other about ways of managing minor health ailments, more South Africans can have access to first line health services.

Recommendations

From the results of the study, the following recommendations are made:

Older people

- Older people need to share their experiences with the outside world as people who were the first line managers of health problems whilst resources were scarce.
- Consensus reaching and collective decision-making technique used by older people might also help health workers and older people to reach common understanding about what is minor ailment and appropriate strategies that can be used for managing those minor health ailments.
- To ensure that the remedies or home-based medicine is available to the respective communities.

Youth

The study revealed that information can be passed from generation to generation (see pg 86), therefore the youth must give older people a chance to open their cell of wisdom and share experiences about management of health problems using indigenous knowledge systems. Indigenous health knowledge system is part of our cultural heritage that needs to be treasured and utilised. One example is that oral histories can be taken by the youth from the older people, and written down or captured electronically, to ensure that the wisdom and knowledge is not lost.

Community health centre authorities

- The management needs to start establishing programs that will let the western and the traditional medicine meet each other.
- The authorities need to re-open discussions with older people about a way forward of solving the problem of overcrowding CHC's at both Khayelitsha and Phillipi.
- Health authorities need to recognise the important role that can be played by older people.
- The Department of Health need to do further investigate on the effectiveness of these remedies and treatment dosages to determine scientifically which ailments could be treated with success at home and which cannot be treated.

Community

The Makhulu and Tatomkhulu tatomkhulu project has got the responsibility of facilitating the following activities:

- To encourage communication about health between families, older people and health workers.
- To enlighten the community about indigenous health knowledge used for management of minor health ailments.
- To enlighten communities about health ailments that needs to be treated at hospital and those that can be managed at home.

In order for the project to work effective, it must collaborate with relevant stakeholders i.e. Social services as people who also have directorate for older people and who according to this study sponsor some of the senior citizen centres, Community Health Forum who discuss health issues on a weekly basis and health authorities in the respective communities.

REFERENCES

Armentrout G, 1998: Community Based Nursing – Foundation for practise. Simon & Schuster Company. United States of America.

Barber J.H, 1984: General Practise Medicine. Churchil Livingstone Inc. New York.

Bhat R & Jacobs T, 1995: Traditional herbal medicine in Transkei. Journal of Ethno Pharmacology, 48: 7-12.

Brice N, MacGurk C, Petkar F & Phillip S: The health seeking behaviour of patients with minor ailments. University of Cape Town.

Buhrmann M, 1983: Community Health and Traditional Healers. Psychotherapeia: 15-18.

Cameron J, 2005: Fairlady Magazine – Volume 817.

Coulson N, Goldstein S, and Ntuli A, 1986: Ottawa Charter. W.H.O. Conference Health Promotion Journal, 1(4): 3-5.

De Haan M, 1996: The health of Southern Africa. Juta &Co, Ltd. Cape Town.

Denhill K, King L & Swanepoel T, 1999: Aspects of Primary Health Care; Community Health Care in Southern Africa. Oxford University Press: Cape Town.

Department of Health, 2004: Celebrating the achievements of Alma Ata; Strengthening Primary Health Care in South Africa. South Africa.

Eisenberg M.D, Ronald C & Kessler P.D., 1993: Unconventional Medicine in the United States. The New England Journal of Medicine 328(4): 246-252.

Fry J & Hasler J.C., 1986: Primary Health Care 2000: Churchill Livingstone Inc, New York.

- Froggatt A, 1990: Family work with elderly people: London, Macmillan Education.
- Gessler M.C, Msuya M.H.H. & Nkuya A, 1995: Traditional Healers in Tanzania: Sociocultural Profile and Three Short Portraits. Journal of Ethno- Pharmacology 48: 145-160.
- Green Africa Network, 1993: Surveying Lou Herbalist to preserve indigenous Knowledge and establish Sustainable sources for in expensive and effective medicine. Kenya.
- Guma M, 2004: The Social Context and Relevance of Indigenous African Medicine. Centre for Extra-Mural Studies, University of Cape Town.
- Gumede W.V, 1990: Traditional Healers. Skotaville Publishers, Braamfontein.
- Hammond – Tooke D, 1989: Rituals and Medicines. Creda Press, Cape Town.
- Hattingh S, 1996: Gerontology. National Book Printers, Cape Town.
- Jeebhay M, Hussey G & Reynold L, 1997: The New World Order – A challenge to Health for All by the year 2000. Health System Trust, South Africa.
- Katz S & Kimani V 1982: Why do patients go to Traditional healers. Department of Community Health – University of Nairobi, Kenya.
- Keeran Q, Naidoo K.V, Parker A & Royker A, 2000: Determining the health-seeking behaviour of clients presenting with minor ailments attending Michael Mapongwana C.H.C. University of Cape Town.
- Kubukeli P, 1999: The Lancet. Traditional healing practices using medicinal herbs, (345): 24.

Liddell C, Barret L & Bydawell M, 2004: Indigenous representations of illness and Aids in Sub-Saharan Africa. Social Science & Medicine 60: (2005) 691-700.

Mackenna M, 1996: Alternatives to Antibiotics. Struik Publishers, Cape Town.

MacLachlan M, 2004: Culture and Health module. Centre for Global Health and Department of Psychology – Trinity College. University of Dublin.

Marshall C & Rossman G.B, 1995: Designing qualitative research. Sage Publications Inc. London.

McWhinney I.R, 1997: A textbook of Family Medicine. University Press Inc. New York.

Medical Research Council, 1997: South African Healers' Primary Health Care Handbook. Copycat Communication, Cape Town.

Merteerns A & Gray F, 1973: The Xhosa: Purnell Publishers. S.A.

Mtyaphi M, 2001: Key informant. Khayelitsha.

National Research Foundation, 2001: Indigenous Knowledge System document.

Ngada N.H & Mofokeng K.E, 2001: African Christian Witness. Cluster Publications. South Africa.

Owen C.P, 1995: Policy for the development of a district health system for S.A. Pretoria, Department of Health.

Reader's Digest Association South Africa, 1988: Illustrated history of South Africa. (Pg 150 – 154) United States of America printers.

Reddy P.S, 1996: Reading in Local Government Management and Development – A South African Perspective. Juta & Co, Ltd, Cape Town.

Spector R.E, 1997: Cultural Diversity in health and illness. Prentice-Hall, U.S.A.

Statistics South Africa, 1996.

Sunday Times Lifestyle, Volume 16. 1999.

Van Wyk B, Van Oudtshoorn B and Gericke N, 1997: Medicinal plants of South Africa. Tien Wah Press, Singapore.

Vaughn S, 1996: Focus Group interviews in Education and Psychology, Sage Publications, London.

Visalli G & Shepherd S, 1999: Guide to Medical cures and treatments. Cape Town.

West M & Morris J, 1976: Abantu, Introduction of Black people of South Africa. C.Struik Publishers, Cape Town.

Western Cape Province Ministry of Health and Social service strategic management, Draft 4, 1996.

www.demon.co.uk/ailments.htm2001/05/11.

APPENDIX 1

PERMISSION REQUISITION LETTER

Makhulu and Tatomkhulu Project
Khayelitsha Community

To whom it may concern

Request for a permission to conduct a study in your premises

I, Mbuyiseli Zonke, am registered for M Sc (Med) student at the University of Cape Town. I request a permission to conduct a study on your premises. The study aims to determine the indigenous health knowledge of older people in managing minor illnesses. This will involve recruiting the Makhulus and Tatomkhulus who are willing to participate in the study. I would appreciate if the venue could be made available where the focus groups can be conducted. The study will assist in encouraging clients to care for their minor ailments at home using the knowledge of the Makhulus and Tatomkhulus where it is appropriate.

I look forward to receiving your response regarding this issue.

Thank you

.....

M. Zonke (Researcher)

M Sc (Med): UCT

APPENDIX 2

CONSENT FORM

I,hereby give consent to partake in the Research project conducted by Mr Mbuyiseli Zonke. I understand that this will take place in the form of group discussions and that there will be no interventions from the researcher. I understand that all information gathered here would be highly confidential. If during discussions, researcher notes a harmful practice, he will discourage me from the use of that harmful practice for the management of minor ailments that I use at home. He will further inform managers of the CHC's of that practice.

Signature.....

Date.....

University of Cape Town

APPENDIX 3

I-FOMU YEMVUMELWANO

Mna....., ndinika imvume yokuthatha inxaxheba kwezi zifundo ezenziwa ngumnumzana u-Mbuyiseli Zonke. Ndiyazi ukuba kuza kuqhutywa iingxoxo zamaqumrhu kwaye umpandi akayi kuba nagalelo xa sixoxa. Ndiyayazi nokuba ulwazi endiya kulunika luyimfihlo yaye luyakusetyenziswa kwezi zifundo kuphela. Xa kuxoxwa mhlawumbi kuye kubonakale ukuba ezinye iindlela endizisebenzisayo ziyingozi, ndiya kulunyukiswa yaye andiyi kukhuthazwa ukuba ndizisebenzise, nabaphathi bezibhedlele baya kuchazelwa ngalo mkuba.

Umsayino.....

Umhla.....

APPENDIX 4

INTERVIEWING SCHEDULE

The exploration of indigenous health knowledge carried by older persons in the management of minor ailments in Khayelitsha and Phillipi

Research Questions

1. What are the common illnesses that the Makhulus and Tatomkhulus used to manage at home?
2. What were the home remedies that they used in managing these minor illnesses?
3. When would older person give up using home remedies and refer to an outside source?
4. Who would they be referring to for further management of the illness?

APPENDIX 5

UVAVANYO OLUCWANGCISIWEYO

Uphando ngolwazi lwemvelo kwezempilo olufumaneka koo-Tatomkhulu nakoo-

Makhulu malunga nonyango lwezigulo ezincinane e-Khayelitsha nase- Phillipi.

Imibuzo

1. Zeziphi izigulo ezincinane ebezisakunyangwa emakhaya ngoo- Makhulu noo-Tatomkhulu?
2. Ngawaphi amachiza ebesakusetyenziswa xa kunyangwa ezi zigulo zikhankanywe apha ngentla?
3. Abantu abadala babencama xa kutheni ukusebenzisa la machiza, mhlawumbi emva kwexesha elingakanani?
4. Xa bencamile, bebemthumela kubani umguli lowo?

APPENDIX 6

DEMOGRAPHIC INFORMATION OF SENIOR CITIZEN CENTRE

Name of the senior citizen centre.

.....

Where is it located?

.....

When was it opened?

.....

Who is sponsoring the centre?

.....

How many older people utilize this service?

.....

Are they paying any money? Explain

.....

What type of activities are they doing?

.....

Who are the managers?

.....

Are there any meals provided? Explain.

.....

Thank you for your cooperation.

M.S. Zonke

Researcher

APPENDIX 7

POST-FOCUS GROUP QUESTIONNAIRE FOR THE WILLING PARTICIPANTS

This questionnaire is mainly for presentation of the results and may not be used for any other reasons, so fill free to answer it without hesitance.

Name:

Address:.....

How long have you resided at Cape Town?.....

Do you have any rural background, specify?

Did you personally use herbs for health problems?.....

Did you use these herbs on anyone, i.e. your children?.....

Did it work?.....

Do you think it that using of herbs at home may control overcrowding at the day hospital?.....

.....

Thank you for your co-operation

M. Zonke (The researcher)

APPENDIX 8

RAW DATA COLLECTED FROM MASITHANDANE SENIOR CITIZEN CENTRE

Umpandi: Yintoni igama lale club?

Abantu: Yi-Masithandane.

Umpandi: Yeyalapha eHarare?

Abantu: Ewe.

Umpandi: Ndiyanibulela ke booMama nani booTata ngokuvuma kwenu ukuba yinxalenye yoluphando-lwemveli. Umongo woluphando-lwemveli lulwazi lwemveli oluqulathwe nini malunga nokunyangwa kwezigulwana ezincinci apha ekhayelitsha. Xa ndizakukhe ndibuyisele ingqondo zenu emva kancinci, uphando lujongene nokuba ngexesha izibhedlele zazisekude ngasemakhaya, kwakusenziwa njani xa kugulwayo emakhaya? Okokuqala kuzakufuneka undichazele ukuba zeziphi ezizigulwana zincinci zazikwazi ukunyangeka emakhaya? Nizichaze zonke izigulwana ezo ngokuzazi kwenu nendlela ezinyangwa ngayo. Bendizakunicela xa nithethayo nizame ukuwaphakamisa amazwi enu. Ekwesibini ndizakucela ukuba kuthethe umntu abemnye ngexesha ukwenzele ukuba ishicileleke kakuhle lontetho okanye incazelo.

Siza kudwelisa zonke izigulwana ebezinyangeka phaya emakhaya

Zeziphi ezizigulwana zincinci bezinyangeka emekhaya ngexesha lakudala.

Abantu: Isigulwana ebesinyangeka kuqala isisu. Isisu esibuhlungu nesilumayo. Intloko eqaqambayo, ikhohlokhohlo, indlebe ebuhlungu okanye ebhobhozayo, umqala obuhlungu, isifuba esiminxeneyo esibuhlungu esivalekayo maxa wambi, nelido (lphuma apha emnweni okanye phantsi konyawo).

Umpandi: Ilido yahlukile kuchwane?

Abantu: Unomohluko kuchwane. Abanye bayibiza ngokuba sisifesane. Ndiyayibona , yilento kuthwa yifeet?

Umpandi: Zeziphi ezinye izinto?

Abantu: Irhashalala, ithumba

Umpandi: Zeziphi ezinye izifo ezithi zihlasele abantwana? Ziphi ezizifo bathi bagqithe kuzo abantwana abancinci xa bekhula.

Abantu: Enye yezozifo yiMasis.

Umpandi: Zeziphi kubantwana abadala.

Abantu: Oqwilikane, kuba bebenywanga kudala.

Umpandi: Yeyiphi enye?

Abantu: Ingqakaqha, unkonkonko

Umpandi: Ingaba ziphelile izigulwana azinyangwa kudala?

Abantu: Umntwana aphantswe kukudumba. Aziphela kukho intamo ngelinye ixesha lentamo umntwana umxhuzulise. Isifo sokuwa ukuxhuzula? Ewe. Kanti nomntu omdala ebeyenza intoba naye axhuzule. Izilonda bezikwazi ukunyangwa kudala. Ewe besikwazi nemvuma. Umntwana ebethanda ukuba nemvuma apha emehlweni avaleke amehlo angaboni.

Umpandi: Into ezakuthi yenzeke sizakuzicalucalula nganye nganye izifo esizikhankanyileyo. Okwesibini sizakuthi sisichaze indlela ebezinyangwa ngayo isifo ngasinye. Sizakuchaza ukuba zintoni ezi bethi zisetyenziswe ekunyangeni ezizifo. Sichaze nendlela bezilungiswa ngayo (preparation). Ubusithini umlinganiselo ze aphile emva kwexesha elingakanani isigulana?

Isisu

Umpandi: Ngoko sizakuthi siqale ngesisu.

Abantu: Isisu besinyangwa ngorharhayo.

Umpandi: Ukrakrayo?

Abantu: Ewe, besinyangwa ngokrakrayo isisu ukuba awuselanga krakrayo usela uzifo zonke.

Umpandi: Ubusela kangakanani, ngecephe okanye ikomityi?

Abantu: Ibiba yihafu yekomityi sitsho siphela isisu.

Umpandi: Siphela emva kwexesha elingakanani?

Abantu: Ibiphela imini noko sekucaca icala. Ibiba yimizuzwana nje. Mna ndazi ngokwakwantu ilitshongwe elimbiwayo. Lenziwa ntoni,

Umpandi: Lisenziwa njani itshongwe olo?

Abantu: Itshongo liyakhiwa ligutywe. Uguba umthi lo weyeza uselise umntu onesisu.

Umpandi: Ulidibanisa namanzi abandayo?

Abantu: Ulidibanisa namanzi abandayo nokuba uyalipheka ulidibanise namanzi abandayo liyaseleka. Ukutsala kwalo unika isigulana sisele?

Umpandi: Liselwa libanda lingabi shushu?

Abantu: Ulisela lipholile. Emzuzwini esele umntu siphelile, sibebhetele. Isisu kuzindidi ezahlukenayo. Kukho nesibizwa ngokuba sisisu segazi. Nelagazi lisenziwa zintshulube ingakumbi apha ebantwaneni. Uthi kanti umntwana unentshulube ezithi zidale esosisu kubekho negazi. Ezintshulube ziyamtya umntwana apha ngaphakathi abeyilonto ebangela elagazi. Kutsho kuthiwe kengoku lithontsi. Kwelagazi uti ucedwe litshongwe. Intshulube ziyayoyika into ekrakrayo. Kwakudla ngokuthiwa kudala xa udle ipesika eziluhlaza uzakuba nesisu segazi.

Umpandi: Yinyani leyo?.

Abantu: Oh yayinyani leyo. Ewe liyanceda apho ke itshongwe. Ezipesika ziluhlaza zinobaboyana kwakungarayithanga ukuba zityiwe. Oba boyana busezipesikeni bebujika bubeyi poison apha ngaphakathi busongane apha emathunjini. Yiyo ke lo nto ziluma apha esiswini. Isisu siluma naxa sinomoya omdaka ongolileyo, wona unyangwa nge-Qwili, lelona yeza lisebenza kakhulu.

Umpandi: Lona eli qwili lisetyenziswa njani?

Abantu: Uyaliqhekeza uhlafune, uginye amathe alo. Emva kwethutyane uva isiqabu. Kanti nothuvane uyanceda. Heke uthuvane uyamazi uthuvane, hayi andimazi. Uthuvane uqhephula nje kancinci uhlafune uginye amathe akhe. Apha esiswini uve isisu sisitsho, ziqhawuke zihlangana, sipele isisu emva koko? Sipele isisu emva koko.

Umpandi: Ingapha ikhona enye indlela engenye yokunyanga isisu ngaphandle kwezi nizikhankanyaleyo?

Abantu: Hayi zezo kuphela.

Umpandi: Hayi ke masigqithele kwesinye isigulo.

Intloko ebuhlungu / eqaqambayo

Umpandi: Intloko ebuhlungu ibinyangwa njani?

Abantu: Uthatha I- Tshongwe umgwadise umntwana ngokuthi ulifake ezimpumlweni, athimle umntwana, aphile, Mmh, intloko ithi ham.

Umpandi: Igwada kuphela?

Abantu: Ewe igwada lodwa. Ungasebenziswa eli lithengwayo, ela ligutyiweyo.

Okanye utshisa irhonya elidala, lithi lakuqhuma, urhogole umsi walo. Emva kwethutyana elingephi uva isiqabu. Kungenjalo uthathe iqhiya emnyama le inxitywa ngomakoti, uyitshise, urhogole umsi walo. Le kutiwa yi khetshe miya.

Umpandi: Ikhona enye indlela engenye yokunyanga intloko?

Abantu: Hayi yayizezo kuphela.

Umpandi: Bekusithiwani xa ingapheli ke intloko?

Abantu: Hayi umntu ebephila zezi ndlela sizikhankanyileyo.

Umpandi: Hayi ke masiye kwelandelayo

Ukhohlokhohlo

Umpandi: Ukhohlokhohlo belunyangwa njani?

Abantu: Ukhohlokhohlo lunyangwa ngeqwili ngeqwili.

Umpandi: Ewe, lenziwa njani eli qwili?

Abantu: Uyaliqhezula ulipheke namanzi. Emva kokuba uliphekile laphola, usela ngekopi. Ewe umane usela ngekopi, liyavundisa apha ngaphakathi. Liyavundisa ngaphakathi. Ewe.

Umpandi: Iqwili nje lodwa?

Abantu: Ewe iqwili lodwa. Uphinde ukhe u-Mhlonyane uwuxube nobushwa. Zombini ke ezi zinto zikhiwa emfuleni.

Umpandi: Uzenza njani ke zona?

Abantu: Uthatha amagqabi azo uwafake emanzini abilayo, uwapheke, ze uwupholise lomxube. Xa upholileyo useza umntwana ngecephe, omdala ngehafu yekopi.

Umpandi: Ibithatha ixesha elingakanani ukunyanga ukhohlokhohlo?

Abantu: Belithi litshona ilanga uve umahluko, ze kusuku lwesibini lube luphelile ukhohlokhohlo. Kanti namagqabi o-Mgamtriya ayanceda. Nawo ubuwathatha uwapheke. Athi akuphola uwasele. Kanti nanamhlanje ndikhe ndilenze igqabi legamtriya ndisele,

kuse iphelile. Eh ezanto thina sisazenza. Xa usela ingathi usela ezi-Borstol zenziwayo namhlanje.

Umpandi: Iphilisa emva kwexesha elingakanani ke yona?

Abantu: Emva kwentsuku ezintathu.

Umpandi: Ikhona enye indlela yonyango?

Kumntu omdala ngelinye ixesha, ubuthatha amagqabi o-Mhlonyane uwafake apha ezimpumlweni, ukuze uphefumle lona, uva isiqabu msinyane. La magqabi avula iimpumlo ezimfixeneyo. Uzi vula iimpumlo zibe zinkabankaba.

Umpandi: Likhona elinye ichiza lokhohlokhohlo?

Abantu: Hayi aphelele kulawo.

Umpandi: Masiye kesinye isigulo.

Iindlebe

Umpandi: Iindlebe ezikhathazayo bezinyangwa njani kudala?

Abantu: Uthwala incamasi. Indlebe ebesiya sithi kuthwa liphima, Yha, ndiza kulonto kanye. Yiza mama. Kulonto kuthwa liphewulane pha entabeni ngoku usukuthi xa umntwana eqaqanjelwa yindlebe uye pha entabeni oyokukha elakhowa lidesi elakhowa ufike kengoku ulisile so ulibeke enantsikeni enkcenkceeni phezu kwamalahle kuphume la manzi. Mmh, ufuna la manzi lamanzi ngoku wakube ufumene la manzi ke ngoku uthathe itshefu ukhamele umntwana apha ezindlebeni. La manzi ayo. La manziwayo, uphinde ulibeke. Uphinde nagokuhlwa umntwana xa ezakulala umkhamele ufake kwakungekho noboya ke unqontsule ibhayi elidala, uchize e ela bhayi lidala usike intwana ufake apha ezindlebeni. Yenzela ukuba ingaphumi. Ingaphumi? Ha ha ingangenwa ngumoya uphinde naxa ulala uphinde wenze la nto, woje ela khowa ulikhamele ufake ilatshana.

Umpandi: Zintsuku zingaphi iphele lo ndlebe ikhathazayo? Ibiba zintsuku ezingaphi?

Abantu: Noko yayingathathi kwantsuku wawuthi ukuba umkhamele namhlanje ukuba ibiqaqmba umve ngengomso ukuba ulele kange umve ekhathazwa. Ngengomso seledlala pha, xa umbuza ukuba indlebe injani, athi hay mama iphilile. Okay mmh. Iphewula selisetyenziswa kakhulu nje-Flowers apha emizini yabelungu bahombisa ngalo.

Umpandi: Ingaba nisalisebenzisa nanamhlanje ke?

Abantu: Ewe asikayiyeki ukulisebenzisa. Indlebe egalelwe lona ikhawuleza iphele. Ngelinye ixesha bekusetyenziswa amafutha enja yaselwandle.

Umpandi: Amafutha enja yaselwandle?

Abantu: Ewe, uyawapheka nje nawe, ugalele iqabaza apha endlebeni. Uvale indlebe wakugqiba angaphumi la mafutha.

Umpandi: Emva koko kuthini? Iphila emva kwexesha elingakanani?

Abantu: Ibingathathi xesha libheke phi.

Umpandi: Zintsuku zingaphi?

Abantu: Hayi ibithatha usuku okanye ezimbini iphile. Kanti ngelinye ixesha ubuthatha amafutha enkukhu, apha kwindununu yenkukhu. Nawo uwathi qaba apha endlebeni, akufika phakathi iyakuxelela indlebe.

Umpandi: Kwenzeka ntoni?

Abantu: Ibiba bhetele indlebe yomntwana ngoko nangoko. Ibingathathi xesha lide.

Umpandi: Injalo lo nto gogo?

Abantu: Hayi injalo mntanam.

Umpandi: Kumnadi ukuzazi ezi zinto. Ezinye izinto siye sizithathe ngathi azinamsebenzi. Nizithatha kancinci. Ewe kanti zinomsebenzi. Iindlebe ezibhobhoza zona?

Abantu: Iindlebe ezibhobhozayo ubuthatha phaya uzifo zonke, umgalele emanzini adikidiki, uthathe usiba letyiphu, wawuthu ukhangele la athambileyo apha etyiphini asezantsi athambileyo mancinane antsakantsaka uthi nkxu kula zifozonke. Uye ucoce lo ndlebe ngozifozonke, yena uhlamba oba bofu bubhobhozayo. Uhlambisise ngela siba. Uyayazi mos ukuba le ndlebe iyaqaqamba inobofu nje, uzokuya kweza nto ukuba awuyanga kumafutha enja yaselwandle okanye uye kula asetyiphini, amafutha etyiphu, uqhontsize pha uyivale wakugqiba. Mmh. Ewee izakuphila uzakumane uyihlamba ukutshona kwelanga ukhuphe ubofu uve ukuba akusafani nakuqala. **Umpandi: Ibithatha iintsuku ezingaphi?**

Abantu: Ibithatha iintsuku ezintathu. Kaloku ezi ndlebe zibhobhozayo zenziwa ngelinye ixesha xa umntwana engaphumanga ishimnca ngokwaneleyo.

Umpandi: Liphume ngendlebe?

Abantu: Ngoku liyaphuma de ngelinye ixesha limvale indlebe umntwana. Angeva. Xa libhobhoza ithetha ukuba khange liphume kakuhle. Ingaba ikhona enye indlela yokunyanga indlebe ebhobhozayo?

Umpandi: Ikhona enye indlela engenye?

Abantu: Hayi ayikho enye.

Umqala

Umpandi: Umqala obuhlungu ubunyangwa ngantoni?

Abantu: Ubuthatha I-Gangashane.

Umpandi: Lifumaneke phi ke lona?

Abantu: Lona likhiwa emlanjeni. Amahlamvu alo afana ne-flower angathi ngumfino. Ewe qhuba, uthatha iingcambu zawo izithi chimfichimfi, uzigalele emanzini adikidiki urharhaze ngawo. Emva koko? Iwubetha umqala uye kuxela I-Gangashane.

Umpandi: Iphilisa emva kwexesha elingakanani?

Abantu: Lusuku lunye, kwelesibini akeva nto tu.

Umpandi: Hi uthini na?

Abantu: Ewe elo Gangashane ke abanye abantu bathi liyeza lesikhalo. Oh. Eh lokubethumoya. Oh liyeza lesikhalo. Alinamntu umdala uyalenza nasemntaneni eloGangashane silitshoyo kobethumoya. Ingaba ikhona enye indlela yokunyanga umqala. Enye indlela kuye kuthiwe makarharhaze nangozifozonke. Yona uthatha nje I-Teaspoon likazifozonke, hayi uthatha nje intlantsi yakhe ngoba ustrongo. Xa ugqithisa angabhubha umntu.

Umpandi: Ngako oko ungagaleli ngeteaspoon.

Abantu: Hayi, uthatha nje intlantsane ugalele emanzini urharhaze.

Umpandi: Yena ke uzifozonke uthatha iintsuku ezingaphi?

Abantu: Yena uyakhawulezisa, kusuku lwesibini sesitya umguli, ngako oko zinntsuku zimbini uphele umqala.

Umpandi: Ngaphandle kwezi zikhankanyiweyo, ikhona enye indlela engenye?

Abantu: Uthatha I-Aleni, ukuhle amaqhakuva la asemqaleni. Isrongo ikhawuleza iwabulale ama qhakuva emqaleni. Ithatha nje ithutyana elingephi.

Umpandi: Ikhona enye indlela ngaphandle kwezi?

Abantu: Hayi ziphelele.

Umpandi: Masiye kwelandelayo.

Isifuba

Umpandi: Isifuba esibuhlungu besinyangwa ngantoni?

Abantu: Isifuba esi uye uthathe I-Sivumbampumzi esi, usikhande usifake emanzini abililelyo sikhale sibile usiyeke siphole wakugqiba sisele. Uphinde xa ulalayo usikhe usihlafune, kusasa isifuba sakho sithambe ukanti isifuba esi asomanga.

Umpandi: Ithath ixesha elingakanani?

Abantu: Uyisela namhlanje , ngomso uziva ubhetele, kwelilandelayo usuku uphilile.

Umpandi: Xa sivalekile isifuba bekusithiwani ngoba esivalekileyo sehlukile kwesixineneyo?

Abantu: Xa sivalekileyo isifuba ubuye uthatha u-Mhlonyane, uwupheke, wakuphola uthathe amafutha enja yaselwandle ugalele kulo mhlonyane. Uye umselise umguli ihafu yekomityi kusasa nangokuhlwa. Lo mxube uye usivule kwangoko esi sifube siminxeneyo.

Umpandi: Sivulwa ngala mafutha nomhlonjane?

Abantu: Ewe kaloku la ndawo ihamzelayo kumhlonyane I-good xa idibene namafuthe enja yaselwandle. Amafutha enje yaselwandle ayathambisa apha ngaphakathi.

Umpandi: Ithatha ixesha elingakanani?

Abantu: Zintsku simbini nje, kolwesithathu sivuleke singumnkabankaba.

Umpandi: Xa singaphili bekusithiwani?

Abantu: Hayi bekusiyiwa kosiyazi, bona bebehaza intsukaphi yaso, bakugqiba basinyange.

Umpandi: Ikhona enye indlela yonyango?

Abantu: Hayi ayikho enye.

Umpandi: Masigqithele kwelandelayo.

Isifesane

Umpandi: Isifesane besinyangwa njani kudala?

Abantu: Uthatha ingxakangxaka, kukho umthi ekuthiwa yingxakangxaka. Uyayoja kuqala, okanye uyipheke embizeni ibe shushu nje, uyikhuphe uyijjele kulo mnwe unesifesane ngelaphu.

Umpandi: Lonto wenzela ukuba ithini?

Abantu: Wenzela ukuba igqabhuke. Ukugqabhuka kwayo yiyeke yophise, ithi iphela iveki ibe iphelile tu.

Umpandi: Nentlungu ziphelile?

Abantu: Ewe ziphelile.ithatha iintsuku ezimbini ukuze itsale, emve kokutsala igqabhuke.ekugqabhukeni kwayo iyaphola ke tu. Yiyo lento ndithi ithatha iintsuku ezimbini ngoba kwelestithathu iyaphola, ithi iphela iveki, ibe iphelile.

Umpandi: Ikhona enye indlela yokunyanga isifesane?

Abantu: Ewe ubuthatha I-sunlight uyenze shushu ugalele iswekile, uqabe kulo mnwe, uwubophe, kusuku lwesibini iya kugqabhuka, iphole kolwesithathu. Xa unento ephumayo ongayiqondiyo, yikhawulezele kwangoko, wenze ezi zinto sithetha ngazo.ubhandishe wathi eli qhakuvana ulibone ukuba linentloko emhlophe, hayi bo isenokwenzeka izakuba lithumba eli okanye mhlawumbi isifesane zonke ezo zinto ziyadibana uzibophe zithi nkqi.

Umpandi: So niyikhawulezele?

Abantu: Ewe siyayikhawulezela.

Umpandi: Masihlabela mgama ke Bantu abakhulu.

Irhashalala

Umpandi: Irhashalala ibinyangwa ngantoni?

Abantu: Ubuthatha iingqatha zebhokwe uzidibanise namanzi uzicubhe uqabe umntwana umzimba wonke.

Umpandi: Makuthethe umntu abemnye ngexesha. Yiza mama.

Abantu: Ndithi ke bawo ubuthatha iingqatha zebhokwe uzikrwece zibe yintlama, umqabe ngayo umntwana yonke indawo. Wakugqiba umseze umhlonyane

Okanye lo mxube wengqatha zebhokwe kangangecephe kathathu ngemini.

Umpandi: Ebeye aphile emva kwethuba elingakanani?

Abantu: Ubuye uyigqibe nokuba yiveki umntwana engakhathazwa nto eza zinto ziyabuna, lo mxube uyawabunisa amaqhakuva.ithi iphela iveki abe ephilile umntwana.

Umpandi: Heke yiza Mampinga?

Abantu: Umntwana xa enerhashalala akufuneki abone ilanga phandle, kufuneka ehleli endlini, umvalela egumbini de abune amaqhakuva, uthi akubuna ke umyeke aye kudlala phandle, kodwa ungayeki ukumseza umxube icephe kathathu ngemini. Xa umntwana engakhawuleziswa ngonyango yayibulala ke irhashalala.

Umpandi: Wena mama ingathi ufuna ukuthetha?

Abantu: Hayi ndifuna ukuyingqina ukuba xa umntwana engakhawuleziswa wayesifa.

Umpandi: Ikhona enye indlela yokunyanga irhashalala?

Abantu: Hayi yileyo kuphela.

Umpandi: Masiye kwenye msinyane.

Ithumba

Umpandi: Ithumba lalinyangwa njani?

Abantu: Eh kwakungo 1945 ndiku two esikolweni, zangaka iingalo zankulu andiyazi nokuba kuza kugqabhuka kwakweli cala nentamo yankulu nendlebe ze sa. Kwakubekelwa yonke ke into ngenantsika. Kwakubekelwa ngantoni? Ngespha eluhlaza le inamachokoza. Le iluhlaza? Ewe kanye leyo kwenziwa intlama ngayo ibekelwe kwithumba lonke. Lithi lakugqabhuka kulo ndawo likuyo zitsame nezinye indawo. Lavuma umgqobho omkhulu kulo ndawo. Kodwa ke kwe qabu emva kwalonto. I-Thumba yinto ephuma naphina. Likhona elikhulu kuthiwa nguThumbankulu kanti likhona elincinci kuthiwa nguthumba ncinci.

Umpandi: Khanitshoni awukho umthi ububekwa ethumbeni?

Abantu: Uthatha iphekepheke le- Zimbanzi ulifake evundwini libe shushu, ulibeke ethumbeni de ligqabhuke.

Umpandi: Ithatha ixesha elingakanani ukuze ligqabhuke?

Abantu: Ithatha iintsuku ezimbini, kwelesithathu liqalisa ukoma liphole. Olwam ulwazi wayesithi umama notata yikhani ikhala apha phandle. Ikhala yilanto kuthwa likhamango. Uyalibona elikhamango lakufika liskwa libe zi pisi lizakutshiswa lojiwe ikhamango libe shushu. Lakuba shushu lithathwe lifakwe elaphini libotshwe apha kwithumba. Umntu

uyakhala noba libuhlungu yaye lishushu yaye litshisa futhi. Akumandanga ke tu, kufuneka la manzi alo aphume aphele apha kwithumba lakho. Kuphinde kuthathwe elinye lojiwe libotshelelwe ngelaphu. Kufuneka yonke lo nto yenziwe de ligqabhuke. Yonke lento yenziwa iintsuku zibe mbini, kolwesithathu liyagqabhuka ithumba kuba kaloku alinikwa chance. Ikhamanga yinkunzi yethumba.

Umpandi: Ikhona enye indlela yokunyanga ithumba?

Abantu: Hayi zezo kuphela.

Uqwilikana

Umpandi: Yena uqwilikana ebenyangwa njani?

Abantu: Ubusiya emngxumeni uthi nje “qwilkana ho phuma yiya kwabanenkomo”. Nangoku senza njalo pha ezilalini.

Umpandi: Apha edolophini?

Abantu: Uyenza kumgqomo apha edolophini.

Umpandi: Yenzeke ke?

Abantu: Ewe iyenzeka. Kudala kwakukhangelwa umngxuma omnyama kuthiwe ke ngoku mntanam yiya kula mngxuma ufike uthi qwiklikana phuma kum yeye kwabanenkomo, wakugqiba ungabheki, ubaleke uyokungena endlini kuza kusa uqwilikana ephelile.

Umpandi: Ephelile?

Abantu: Ewe ephelile.

Umpandi: Ikhona enye indlela yokunyanga uqwilikana ngaphandle kwale?

Abantu: Hayi ayikho enye Qhuqhuqhu.

Umpandi: Masiye kwelandelayo.

Unkonkonko

Umpandi: Xa umntu enenkonko bekusithiwani?

Abantu: Xa umntwana enenkonkonko bekuthiwa makasengelwe ubisi lwedonki okanye elehashe.

Umpandi: Hii uthi ubisi lwedonki okanye elehashe?

Abantu: Ewe.

Umpandi: Umseze kangakanani ke?

Abantu: Nokuba umseze amacephe amathathu okanye ihafu yekopi kodwa ingade igcwale ikomityi. Umane ke umthi laqa umntwana.

Umpandi: Aphele ke unkonko?

Abantu: Ewe aphele.

Umpandi: Emva kwexesha elingakanani?

Abantu: Ibiphela emva kweveki ezimbini ukuya kwinyanga. Ubumbona ukuba uya ebubheteleni ngokuthi umguli akhohlele igazi, yazi ukuba uye ebungconweni.

Umpandi: Ikhona indlela engenye?

Abantu: Hayi ibibalelo bisi ledonki okanye elehashe kuphela.

Umpandi: Masihlabele mgama.

Ukudumba

Umpandi: Ukudumba bekunyangwa njani kudala?

Abantu: Uthatha umhlabangulo uwupheke uthi usakugqiba umthobe ngawo lo mntu udumbileyo kulo ndawo idumbileyo. Qha kufuneka uqinisekise ukuba ushushu xa umthoba.

Umpandi: Xa umthoba usebenzisa ntoni?

Abantu: Hayi usebenzisa nje ilatshana umane ulithi nkxu apha kuwo, umthobe.

Umpandi: Umthoba intsuku ezingaphi?

Abantu: Umthoba iintsuku ezimbini, kolu lwesithathu kuphelile ukudumba. Ngamanye amaxesha awuthobi ngalaphu, uthoba nje ngawo umhlabele lowo. Umntu xa umthoba awumcengi, uyaqinisa ngoba unceda yena. Ngelinye ixesha usebenzisa ela phewula kwakhona.

Umpandi: Lona ulisebenzisa njani?

Abantu: Ubeka macala kulo ndawo idumbileyo, urepisele ngelaphu, umeke. Ade aphela amanzi ela phewula apha kuye. Kangangokuba ukuba udumbe wonke uzakuhambe umbophe ngolu hlobo, iphewula ilaphu ngaphezulu. Ukwenzela la manzi ela phewula aphelele apha kuye. Emva koko ungampinda ngomhlonyane nobushwa.

Umpandi: Umhlonyane nobushwa?

Abantu: Ewe zona wenza ibhotile ngazo asele ngaphakathi wenzela ukuba oka kudumba kuphumele ngaphandle, ze kuhlangele nephewula ke ngoku. Kulapho bungazokufumana ndawo buphume ngaphandle.

Umpandi: Oku dumba kuphela emva kwexesha elingakanani?

Abantu: Iphela iveki kuphelile ukudumba.

Umpandi: Ikhona enye indlela ekunyangwa ngayo oku dumba?

Abantu: Hayi alikho elinye ichiza.

Umpandi: masiqhubele phambili.

Ukuxhuzula

Umpandi: Ukuxhuzula bekunyangwa njani kudala?

Abantu: Ukuxhuzula ebesithi umntwana xa exhuzula pha kudala ke zingekabiko ezi zinto zakwaGqirha, umntu ebekhangela nokuba lilaphu elidala alifake nje apha emlilweni athi abone ukuba ha-a akakwazi kubizela kuba mos uenjenje, ubone kengoku kuthwe makuthathwe la nantsika kokho lento kuthwa sisiqhumiselo.

Umpandi: Kuthwa yintoni kanene?

Abantu: Impepho, heke yiyo ke leyo, kuthathwe impepho le kuqhunyiswe ngelinye ixesha ibanje ibesisikuntyu kuthiwe apha emlonyeni kuthwe apha kuye njegokuba exhozula nje. Njengokuba esenjenje, abi seqala ukubhodla. Umbone ke ngoku ukuba ubuyela ezingqondweni. Uye kulanto kuthwa nguthuvane, asilwe uthuvane abe fine, adityaniswe namanzi abandayo, agalelwe kwihafu yekomityi aselwe. Ndingayazi kengoku kwenzela ukuthini xa esezwa uthuvane umntu oxhozulayo. Kodwa uzakuba right. La msi ke ngoku kudala bekuthiwa ugxotha izinto ezimdaka. Sesithi zintwezimdaka ezi umntu xa exhuzula okanye ugqithwe ngumoya omdaka.

Umpandi: Yiyo lonto eqhunyelwa nje?

Abantu: Ewe ukuwugxotha. Lela gwebu elibangela imithambo yakhe ime.

Umpandi: Njani?

Abantu: Kuba lelagwebu lomoya omdaka ngoko nangoko lize ngamandla ela gwebu lomoya omdaka kengoku lize ngamandla ela gwebu. Yiyo ke ngoku lento ibanga intoba

aziphequle angabi nakukwazi ukuba asebenze ngokuba udaliwe. Kufuneka ukuba asebenze ngokwalomoya umdaka.

Umpandi: Ngokwalomoya umdaka?

Abantu: Ewe, umfaka into embi lelaxakaxa eli limvalayo. Lide lize nakwindawo ebengafuni ziphazanyiswe.

Umpandi: Hayi ke kulungile , ingaba ikhona enye indlela yokunyanga ukuxhuzula?

Abantu: Hayi ayikho enye indlela.

Umpandi: Masihambele phambili.

Izilonda

Umpandi: Izilonda ezi bezinyangwa njani mandulo?

Abantu: Izilonda kwixesha lakudala ikhona lento andisazi nokuba yintoni igama layo ziyandibhida ngoku ezizinto kuba nam ndizikhulele ndandizazi ngelo xesha. Yayikhiwa ke le nto entabeni, ingamagaqana angakanana, lifike ke ngoku aph'endlini lisilwe, lisilwe aqatywe kulo ndawo inesilonda okanye mhlawumbi sisilonda esithe kuhambe kusithiwa kula ndawo, kweza ndawo zinesilonda, uyaqonda. Kusa sibunile ke isilonda, kusas kufuneka sosulwe ngamanzi ashushu, kuphinde kuthiwe sa kwa ela yeza kuso. Kolwesibini usuku siphelile isilonda.

Umpandi: Eli yeza akusalikhumbuli igama lalo?

Abantu: Hayi tu.

Umpandi: Akusekho nomnye olaziyo?

Abantu: Hayi. Isilonda ke kudala besikhawulezelwa singekayi phi, ngoba besiqala ngeqhakuva. Iyeza lesiXhosa belikhiwa lisetyenziswe xa lise-fresh. Thina sasingafani nabantwana bethu, ubusithi xa uqala namhlanje ukugula, unyangwe namhlanje. Abethu abantwana uthi uba uqale namhlanje, athi ndiya ngomso, ugqithe ungomso, uthi esiya kugqirha ube ukugula kukhulile. Enye into enceda isilonda ngamafutha ehagu uwagalele usibabile umqabe ke umguli esilondeni.

Umpandi: Ibithatha iintsuku ezingaphi ukuphila?

Abantu: Ibithatha nganeno kweveki, kaloku isilonda asikhawulezi ukuphola. Usele ngaphakathi esa sibabula kangangehafu yekomityi, sona sikhupha ubumdaka ngaphakathi buye ngaphandle.

Umpandi: Ikhona enye indlela enyangwa ngaso isilonda?

Abantu: Hayi zezo sezikhankanyiwe.

**Umpandi: Masiye kwelandelayo.
Imvuma**

Umpandi: Ibinyangwa yintoni?

Abantu: Imvuma yomntwana inyangwa nje ngebele lomama womntwana?

Umpandi: Njani ngebele?

Abantu: Umdlezane ubesengele ubisi lwakhe apha ezimpumlweni zomntwana, zivuleke iimpumlo zomntwana. Ukanti ke thina kudala ubumfunxa umntwana wakho, ke aba bakhoyo bayonyanya.

Umpandi: Zivuleke iimpumlo?

Abantu: Ewe zibe yinkabankaba. Ibele lomama liyanyanga kakhulu izinto emntaneni.

Umpandi: Ikhona enye indlela engenye ngaphandle kwezi zixeliweyo?

Abantu: Hayi ayikho enye.

Umpandi: Masiye kwenye into.

Ihlaba

Umpandi: Bekusetyenziswa ntoni ukunyanga ihlaba?

Abantu: Bekusetyenziswa uzifozonke. Ubuthatha intlantsi yakhe ugalele kumanzi angange hafu yekopi, usele. Emva kwexeshane, uve lithe cwaka ihlaba. Kanti nomchamo wemfene ubunceda kakhulu lento kuthiwa yi-Dasiepis ngoku.

Umpandi: Uyenza njani yona?

Abantu: Nayo uyigalela emanzini, uyipheke, yakuphola uyisele, ithatha ixeshana liphele ihlaba.

Umpandi: Ikhona enye indlela?

Abantu: Hayi ayikho.

Ukubeleka

Umpandi: Bekubelekwa njani kudala?

Abantu: Thina ngelethu ixesha ububanomchamo wemfene xa uzakubeleka. Uyawusela ngehafu yekopi kusasa qho. Thina sabelekela emakhaya ke. Ubumane usiya kumama othile okwaziyo ukuhlukuhla. Lo mama uza uzakubekela amanzi ashushu athathe itoti yakhe agalele la manzi akuhlukuhle, uzakusijonga isiu sakho ukuba simi kanjani. Asibone ukuba hayi simi kakuhle isisu sakho. Xa simbhoxo nook, si-right. Uzakuchophisa ke lo mama akuseze umchame emfene. Ngolo suku lokubelekisa, lo mama uvuka kusasa angathethi namntu aye kwakho afike asebenze, abelekwe umntwana. Mna wayesithi umama mntanam uthi xa uyokuhlamba emlanjeni, uphethe I-emere usakufika phaya yithi phambi kokuba uhlambe, uthathe amanzi uqale ugalele entloko, emva koko uwakhe amanzi ugalele apha esiswini ke ngoku usibambe ngapha kwelicala, usihlukuhle, uyasibona. Usibethe kanye ulambisile elo xesha. Lonto ke yonke yenza kube lula ukubeleka.

Umpandi: Ikhona enye indlela?

Abantu: Hayi yileyo kuphela.

Umpandi: Umbuzo wokugqibela, xa ke ngoku kuzo zonke ezi zigulo nizikhankanyileyo zingancedakali ngala machiza niwachazileyo, bekusenziwa ntoni?

Abantu: Hayi bekusiyiwa kosiyazi okanye kuzanywe ugqirha okufutshane kodwa ke amaxesha amaninzi la machiza ebesebenza. Bekuye kuyiwe emagqirheni oknye emaxhweleni xa sukuba lonto ixhalisa.

Umpandi: Hayi ke maxhego namaxhegokazi siyabulele kakhulu ngolwazi lwemveli enisicuntsulele lona. Iziphumo zolu phando siya kuninika xa sigqibileyo. Siyabulela kakhulu. Enkosi.