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The *Sangoma* or the Healthcare Center? Health-Seeking Practices of Women Living in the Mangaung Township (Bloemfontein, South Africa)

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Abstract Traditional and Western medicine are both commonplace in South Africa, and are often consulted in conjunction with each other. The article aims to fill critical knowledge gaps in understanding how women as caregivers decide on medication when experiencing illness in the home. In order to achieve valid and rich in-depth understanding about the types of medicine that individuals opt for, a narrative study was conducted. The research participants are women from Bloemfontein's townships. Analysis of the participants' narratives suggests that there are social-economic, traditional, and cultural trajectories associated with negotiating medical treatment. The findings indicate that the context in which individuals give meaning to, diagnose, and treat illness influences their remedial choices. Accordingly, many individuals constantly shift between different types of remedies, as they believe that they yield different, but unique possibilities and solutions.

Keywords Health-Seeking Practices; Illness, South Africa; Caregiver; Western Medicine; Traditional Medicine

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People in post-apartheid South Africa still experience enduring disparities, one of which is Black African people's health. Of the country's total population of almost 55 million, just over 44 million (or 80.5%) identify as Black Africans (Statistics South Africa 2015). The rest of the population is made up of 4.8 million Coloreds (8.8%), 1.3 million Indians/Asians (2.5%), and 4.5 million Whites (8.3%). The life expectancy of South Africans at birth is estimated at 59.2 years for males and 63.1 years for females (Statistics South Africa 2015:2). The health status of Black African South Africans is generally much lower than other population groups and therefore one can assume that the life expectancy of Black African South Africans will be lower than their Colored, Indian, or White counterparts. There are many reasons for lower life expectancy for Black Africans, including unemployment and poverty, but one that has raised attention in the health sector is the HIV prevalence rate. In particular, HIV/AIDS is prevalent among the Black African population. The estimated HIV prevalence of the total South African population is 10.2% (Statistics South Africa 2015), but the HIV prevalence among Black African adults of 15-49 years old is 22.7% as against the 0.6% of their White counterparts (Shisana et al. 2014).

Attending swiftly and competently to the onset of an illness and deciding on a treatment modality is vital and impacts on the health outcome. However, medical help can be delayed when the nature of an illness is associated with stigma such as in the case of HIV/AIDS or sexually transmitted diseases (Besana, Cole, and LaRoque 2011). The home is a space where health decisions are mostly made (Williams

2002:149) and initial health-seeking practices very often take place within the family. The household then becomes a curative space of care where meanings of illness and medications are shaped (Kamutingondo et al. 2011) and where decisions on treatment are negotiated. Several treatment options are available in present-day South Africa in response to different illnesses. These treatment options include seeking help by means of Western medicine, consulting traditional healers, employing complementary medicine, using home remedies, and even reverting to prayers. There is also the option of not treating and/or allowing the illness run its course. The World Health Organization (WHO) estimates that 80% of people in Africa use traditional medicine as their primary treatment modality (Chinsamy 2012), and we can therefore assume that a large proportion of South Africans are doing likewise. Biomedical and indigenous medicines offer different healing properties and individuals are therefore compelled to evaluate the strengths and weaknesses of each method (Hardy 2008).

In Black African families in South Africa, women are often the primary and informal caregivers. Thus, they play vital roles in selecting a treatment modality when a family member is unwell. In this article, which is based on research undertaken in the Mangaung Township, Bloemfontein,¹ South Africa, we discuss everyday health-seeking practices of African women who are their family's primary caregivers and who have to decide on a preferred

¹ Bloemfontein is the capital city of the Free State Province (South Africa); is one of South Africa's three national capitals and is known as the judicial capital of the country. The city is also known as Mangaung, the Sesotho name meaning "Place of Cheetahs."

treatment. These decisions rest upon cultural understandings, the conceptualization of health and illness, the availability of treatment modalities, and the family's financial situation. Social and cultural backgrounds influence how people negotiate medical treatment (Barnard and Turner 2011). To understand health, illness, and treatment, cultural aspects such as what constitutes illness, health, and well-being, as well as associated healing practices, must be considered (Freund and McGuire 1995). Culture is nothing natural or innate, but rather a social construct into which individuals are being socialized (Hagemeier 2011).

What constitutes health is contested and there is no single definition of it (Senior and Viveash 1998:5). The World Health Organization (1998:9) suggested that health should be seen as "a state of complete physical, mental and social well-being; and not merely the absence of disease or infirmity." This is a useful starting point because it suggests a holistic approach and considers physical and mental aspects of well-being. The social aspect, including economic, historic, and political facets, is pertinent because poor economic and harmful social conditions affect people's well-being (Eyles and Woods 1983); also, the cost of comprehensive healthcare often puts quality medical attention beyond the reach of the average poor person.

While South Africa's primary healthcare system aims to provide healthcare for everyone (Lugte, Friedman, and Mbatha 2008), Black African people in the Free State Province, where this research was conducted, experience some of the lowest levels of life expectancy in South Africa (Statistics South Af-

rica 2015). The Mangaung Municipality in particular experiences a shortage of clinics and faces other challenges such as low levels of security, the need to upgrade existing clinics, and the lack of infrastructure maintenance (Tamasane 2013). Thus, the safety and well-being of the Municipality's citizens depending on healthcare at these clinics are often compromised.

The Different Healing Modalities Found in South Africa

The Health Professionals Council of South Africa (HPCSA) assists in developing medical policies and is regarded as the key medical regulatory body in South Africa (de Vries et al. 2009). The HPCSA aims to ensure "quality healthcare standards for all, by enhancing the quality and developing strategic policy frameworks for the effective co-ordination and guidance" (de Vries et al. 2009:121). Medical pluralism is "the co-existence and availability of different ways of perceiving, explaining and treating illness" (Hagemeier 2011:159), with the home often being the place for deciding on and making available medication. The household then becomes a therapeutic space of care where meanings of illness and medications are shaped (Kamutingondo et al. 2011).

The South African healthcare system is a dual medical system comprising of private and public providers. Most Black African citizens of the Free State Province cannot afford private medical care and are therefore obliged to use public health facilities. The Free State provincial biomedical health and well-being infrastructure is distributed

through four health complexes: the Southern Free State Health Complex (SFSHC); the Northern Free State Health Complex (NFSHC); the Eastern Free State Health Complex (EFSHC); and the Academic Health Complex (AHC) (Mohai 2013). These facilities cater for the largest part of the estimated 2.8 million of the Free State's inhabitants, which constitutes a 5.2 percentage share of the country's population (Statistics South Africa 2015). Within these health complexes there are 32 regional and district hospitals, with 155 mobile clinics and 352 clinics (Mohai 2013). Although statistics are unreliable, there are estimated to be around 200 000 traditional healers in South Africa, with a possibility of a traditional healer being in or near the neighborhood of every Black South African (Hassim, Heywood, and Berger 2007; Dickinson 2008; King 2012). The Traditional Health Practitioners Council provides oversight on traditional healers as explained and recognized in the Traditional Health Practitioner's Act (No. 22 of 2007) (King 2012). The national government and the healthcare system therefore acknowledge and support the use of traditional medication. It is not recognized as alternative/non-conventional, but rather as a form of medicine in the healthcare system (King 2012; World Health Organization 2012). It is true to say that traditional health practitioners and users are placed within an "African cosmology" that renders different lifeworld views on medicine to those associated with "scientific inquiry" (Dickinson 2008).

Biomedicine

Biomedicine (often also referred to as Western medicine) refers to "the predominant medical theory

and practice of Euro-American societies, a medicine widely disseminated throughout the world" (Hahn and Kleinman 1983:305). A biomedical approach focuses on the individual and on individual well-being. The starting point for the practitioner and patient is that "something is wrong with the body," and for the professional to treat this wrong thing within the body there has to be a diagnosis—"a cause identified and the body thus fixed" (Hagemeier 2011:145). In this "mind-body dualism," the individual's body and mind are seen as separate from each other and sickness is attributed to the individual rather than to the social or environmental context (Hagemeier 2011). In the biomedical model of health, sickness is treated with medication (Hahn and Kleinman 1983), practitioners are often unfamiliar with patients' backgrounds, and they may lack empathy and humanity while operating state-of-the-art technology (Charon 2001). Patients are treated homogeneously despite diverse cultural backgrounds and different understandings of the illness and healing modalities (Engel 1977). Biomedicine has a culturally specific illness perspective (Engel 1977) rooted in Western and scientific ways of understanding illness (Mokaila 2001). Taking a patient's medical history is thought of as "medicalized tasks directed not at the patient's life world, but at diagnostic evidence" (Hahn and Kleinman 1983:316).

Traditional Healing Methods

African people often draw on indigenous healing modalities. There are many reasons why traditional remedies are favored over Western medication. An indigenous healer often explains the physical or mental illness in cultural terms, which is more

readily accepted or understood than a biomedical explanation (Atindanbila and Thompson 2011). Traditional healing practices are often rooted in wider folk belief systems and they continue to be an important part of many African people's lives (World Health Organization 2002). A further reason for favoring traditional healing is the affordability of traditional medicine.

Indigenous healers provide medical treatment that is not only affordable, but also accessible and available to everyone for any type of illness or problem (Pretorius 1999). A traditional belief system often identifies the causes of an illness as the power of evil spirits, being enchanted by an enemy, or as the result of the anger of certain beings (Hirst 2005).

Complementary/Alternative/Non-Conventional Methods of Healing

The terms "alternative," "non-conventional," "complementary," and "parallel" methods "refer to a broad set of health care practices that are not part of a country's own tradition, or not integrated into its dominant health care system" (World Health Organization 2002:7). Self-medication, a common practice in developing countries (Shankar, Partha, and Shenoy 2002), can be defined as "obtaining and consuming drugs without the advice of a physician either for diagnosis, prescription or surveillance of treatment" (Shankar, Partha, and Shenoy 2002:4). Complementary alternative medicine includes the following healing practices: Ayurveda; naturopathy; osteopathy; therapeutic aromatherapy; homeopathy; phytotherapy or herbalism; chiropractic; therapeutic reflexology; therapeutic massage thera-

py; and Chinese medicine and acupuncture (Hassim, Heywood, and Berger 2007). Influenced by traditional beliefs and low socio-economic status, the use of alternative self-medication is often prevalent in developing countries (World Health Organization 2002).

Some Factors That Influence Medical Decision-Making Processes

It is important to examine and understand health-seeking practices in South Africa and to study factors that influence treatment choices because these impact on the health outcome. Goloba-Mutebi and Tollman (2007) suggest different approaches among poor indigenous people with regard to ill health depending on worldviews and circumstances: a wait and see approach, visiting a traditional healer, a visit to a clinic or hospital, self-medication, or any combination of these. There are many factors that influence decision-making processes, including advice from social networks, cultural norms, socio-economic status, or available treatment modalities (Weiss and Lonnquist 1997). A further important aspect includes the relationship between the caregiver and the sick person.

Individuals seek healthcare in order to maintain or restore health and well-being (Jetten, Haslam, and Haslam 2012), and medical treatment is sought if the illness is perceived as being serious. When assessing an illness, individuals normally categorize the possible medical treatment options available to them by considering three conditional treatment features. The first feature of consideration is whether the medical treatment has any potential consequences

which include harmful side effects. The second feature is whether the diagnosis of the illness indicates a perceived severity (whether the condition has serious consequences). The third feature is whether there is a reasonable prognosis for recovery (Caspi, Koithan, and Criddle 2004). The consideration of treatment options might not always take place in a conscious and premeditated manner.

Prior experience with a medical condition and its treatment often helps a caregiver to choose between different modalities. In most cases, individuals "consider intervention based on convincing repetitive suggestions and personal testimonials" from social network groups (Caspi, Koithan, and Criddle 2004:71). This means that the social network group influences the decision-making process. Most of the time there are assumed power roles in health decision-making and these power roles are occupied by specific people (Besana, Cole, and LaRoque 2011), such as the mother in a household, the giver of care, and the care recipient, often a child.

Factors promoting health-seeking practices have collective, dynamic, and interactive elements that are also influenced by historic and socio-economic elements. In this article, we discuss factors that influence Black African women to select one health approach over another. The study draws in particular on the families' experience of health and well-being over the last five years.

Methodological Notes

Ethical approval for the research was granted by the Ethics Committee of the University of the Free

State's Humanities Faculty. The study was conducted in a resource poor area of Batho in the Mangaung Municipality and data were collected from the communities in the sections known as Lusaka and Maphikela. To qualify for inclusion in this study, a research participant had to be a Black African woman and the primary caregiver of at least one child (being a biological, foster, or adopted child) and to make health-related decisions. Twelve women were recruited with the assistance of a non-governmental organization (NGO) working with women in these particular areas. Semi-structured in-depth interviews, specifically on health-seeking practices, were conducted with six of these women in Sesotho, the participants' native language. The other six women, who participated in an extended project on family life in resource poor areas in Bloemfontein, also offered narratives on aspects of health-seeking. Aspects of these narratives are included in this article. The interviews were transcribed in Sesotho and then translated into English in consultation with other Sesotho speakers in order to obtain the most appropriate English translation.

The study is situated within a qualitative paradigm and applies an interpretive theoretical framework in order to make sense of participants' experiences of reality and their everyday lifeworld (Kelly 2006; Hancock, Ockleford, and Windridge 2007; Creswell 2013). Guided by an interpretive sociological framework, we aim to understand rather than to explain individual experiences and realities. We also aim to understand the complexity, points of commonality and differences between the accounts of the research participants. We employ concepts from

phenomenological thinking, existential phenomenology, and feminist theories to broaden and deepen our understanding of the everyday lifeworld by looking at questions that explore the research participants' experiences and views within real-life contexts (Hancock, Ockleford, and Windridge 2007:4). We emphasize the narrative interpretation of experiences and reality, in which there is a "sequential unfolding of someone's story" (Hancock, Ockleford, and Windridge 2007:14).

The interpretive sociological framework in terms of which this research has been conducted is strongly embedded in social constructionism. In this respect, the article aims at illustrating that the meaning and experience of illness are to a large extent shaped by the social and cultural contexts within which the research participants find themselves. For this rea-

son, the article focuses on the illness experience, the cultural meaning of illness, the way in which the illness experience is socially constructed, as well as the way in which medical knowledge, decisions, and practices are socially constructed. Reality is created by individuals who act within their particular environment and who also act upon environment and circumstances. The research participants in this research therefore enact their practices and decisions regarding illness and they fill these practices and decisions with meaning.

A brief description of the 12 women from the resource poor area of Batho's Lusaka and Maphikela communities in Bloemfontein, who participated in this research, is shown in Table 1. They are the women who decide on and negotiate a cure for an ailment in their households.

Table 1. Participant information.

PSEUDONYM	YEAR BORN	NO. OF PEOPLE IN THE HOUSEHOLD	NUMBER OF CHILDREN (LIVING AND DECEASED) UNDER HER CARE
Dineo	1953	13	11 (including 3 grandchildren and 5 foster children)
Lerato	1942	5	3 (grandchildren), (5 children deceased)
Dimpho	1964	3	2 (including 1 grandchild)
Mampho	1949	3	4 (grandchildren), (1 child deceased)
Karabo	1951	6	7 (including grandchildren), (1 child deceased)
Teboho	1933	4	6 (grandchildren), (7 children deceased)
Nomasonto	1972	8	6 (including 2 grandchildren)
Phaphama	1999	8	6 (including 4 brothers and 1 nephew)
Khomotso	1963	10 and 2 tenants	8 (including 4 foster children, 1 adopted niece, and 1 grandchild)
Khetiwe	1969	13	9 (including 5 foster children)
Lebohang	1998	13	1
Ledisi	n/a	n/a	5 (including 1 grandchild)

Source: *Self-elaboration*.

The Illness Experience

In order to discuss remedies, we first examine what research participants consider as illness. The illness narratives are embedded in the context of the family because being a member of a family is often considered essential for survival. In all cases, family members contribute to the research participants' sense of physical and emotional well-being. The research participants define family in terms of love, trustworthiness, respect, helpfulness, and honor, and families form a support structure in their lives. All research participants experience financial hardship and often illnesses. Other dire conditions within which all the research participants find themselves are unemployment, being the primary carer of the family, the geographical location within which they live, and social and economic factors related to their lifeworlds.

We now discuss the research participants' experiences and the meanings they attach to illness, health, and well-being in order to understand how their perspectives on illness are related to their upbringing, culture, history, and the world of indigenous beliefs *vis-à-vis* the world of Western beliefs. These "two worlds" of indigenous and Western beliefs are not necessarily separate, but rather represent unique worldviews that fuse but also clash at times, and in the analysis of the narratives we indicate how the research participants draw on either world for different, temporally, and contextually influenced reasons. To understand the illness experience, we need to understand the meaning of what constitutes an illness, and to define illness in terms of what we understand it to

be. Based on their realities and experiences, the participants construct their subjective definitions of illness and afford meaning to an illness and its symptoms. Most participants express feelings of fear, panic, and anxiety at the onset of an illness. They dread the illness because of its uncertainty and possible consequences. For our research participants, an illness in the family usually means disruptions to daily routines, further financial hardship, suffering, and even the possibility of death. Because funerals are important traditional cultural events, the participants will, in the event of death, be obliged to provide an appropriate funeral that will add further financial burdens to the family.

From the participants' narratives, it is clear that their meaning of illness deviates from conventional understandings. Most of them believe that illness is when a person cannot move freely. Participants also define illness as something alien or foreign to them. If the illness is perceived to be minor, then the participants call it *mokgotlani*. These minor illnesses (*mokgotlani*) allow for bodily movements to take place and for the appetite to be only partially and temporarily affected (e.g., when one suffers from a headache or stomachache).

You would hear them say: "No, they have only a mild illness [*mokgotlani*]...They are small things, like my foot pains me here." But, you can still work, like the body is in pain, but you can still do things. This is only called a mild illness. When you are ill, it's when you can't move. That is illness. [Teboho]²

² All names used in this article are pseudonyms.

From the stories shared by the research participants, it is clear that they have their own subjective definition of illness, health, and well-being, which is influenced by their social reality. The research participants identify lack of appetite, tiredness, weakness, vomiting, and sweating as the main symptoms of feeling unwell.

You can see sometimes when someone has no appetite for anything. Sometimes they would say: "It hurts here." Sometimes: "I'm running out of energy, I feel this way." Another might say: "When I eat something, I vomit. Maybe it doesn't go well with my system." So you need to clean your intestines. Things like those would help me tell that this person is ill. I have to take them to the doctor, or try to figure out what could heal them. [Lerato]

While the illness experiences might be unique, the participants define illness in similar terms, namely, as a loss of bodily functioning with the person being unable to perform ordinary tasks or partake in daily life activities. According to the research participants, a person is considered ill mostly when her/his ability to take care of her/himself is compromised:

Like being ill? I don't know what I would say it is... When we say this person is ill, it's when they can't stand up and they can't feed themselves. That's when you should know that person is ill. They have an illness...they don't know how to feed themselves. They can't do anything. The person is ill. [Teboho]

To diagnose an illness, participants observe and listen, compare and evaluate a person's physical

appearance and alertness. For most of the participants, illness should not be immediately associated with death, but should be regarded as a mere experience that will probably pass with time. Many participants do, however, refer to it as the correlation between illness and death. This can be ascribed to the high prevalence in their community of serious illnesses related to HIV/AIDS.

HIV/AIDS has a high prevalence in South Africa. It is therefore not surprising that all participants allude to or discuss HIV/AIDS in the context of their families and all participants mention at least one family member who passed away due to complications of AIDS. AIDS remains very stigmatized and is often circumscribed rather than named. Not naming the disease by its name indicates the level of stigma still associated with HIV/AIDS. In some households, it might be acceptable to talk about a family member who is HIV positive, but most families are too embarrassed to discuss it. In the narratives, HIV/AIDS is often simply referred to as being "sick." Lerato says:

It's her, but I don't say much about this thing she has [HIV/AIDS].

And Khetiwe suggests:

I didn't want help from other people, you know, because the children were...because they were positive [HIV positive]. People dislike people who are like that.

Cancer is another serious and prevalent illness, which, together with HIV/AIDS, evokes many emo-

tional responses and reactions. The participants' stories of the various serious illnesses are always accompanied with sadness—either expressed in their voices or through crying. It is clear that serious illness takes an emotional toll on the research participants' lives.

It was cancer, she passed away at National Hospital, where these doctors were checking her. She was admitted there, they even transferred her from National. When I went there, they said her cancer is very huge, there is nothing they can do, they can't even burn it [administer chemotherapy]. When I came back, that was her passing. [Karabo]

It's my mother, she was old and then she had cancer, yes [lowering her voice and facing down to the floor]. She was staying back home, but I went to get her to stay here with me. It was on and off like that, but she was going to the doctor until she was admitted and slept in the hospital. She passed away in the hospital. [Mampho]

In the case of Mampho, both her mother and grandmother died from stomach cancer. Karabo's older sister was also a victim of cancer. In both cases, Western doctors diagnosed and treated the cancer.

The research participants believe that illness can be caused by the environment, lack of sanitation, poor living conditions, unemployment, and an unbalanced diet. Illness might also be a consequence of emotions, spiritual intervention, and witchcraft.

Another reason is because of things that are caused intentionally by people. It is things that are made

intentionally, and these people are envious/jealous. Sometimes these people want to see what you are going to do and it is things like that. But, I still think, maybe it is God's purpose. [Lerato]

How to Deal with Illness?

All the research participants claim to be familiar with the different types of remedies, namely, Western medication, traditional healing, as well as complementary and self-healing practices. Most research participants relate taking similar initial steps to decide on an action. They explain that their medical decision-making processes depend on prior knowledge of a specific illness experience and that they normally replicate what worked for them in the past or what worked for others. The cost of treatment, availability of treatment, type of illness, social networks, testimonials from others, and prior experience with the treatment help the research participants to negotiate medical treatment. "If they are sick," Ledisi relates, "we call an ambulance to take them to hospital." This action is usually taken when the illness is perceived as serious or when seeking medical treatment has been delayed to the point where the patient has fallen gravely ill. Transport is often not readily available, thus calling an ambulance remains an option for poor people who will not be required to pay for this service. The flipside of this is that the demand for public ambulance facilities is so big that calls for ambulance services are often left unheeded for several days. It is quite common that referrals from one biomedical institution to another take place when an individual looks for help within the institutionalized Western medical

services of clinics and hospitals. Khetiwe recalls her experience:

The clinic gave me a referral letter to go to the hospital. The hospital didn't admit them, they just gave them medication. If someone is sick in this house, I take them to the hospital. I start at the clinic, and if they don't help them, then I go to the hospital. I go to National or Pelonomi Hospital, I hire a car, I don't take an ambulance.

The next excerpt summarizes the process that many of the research participants follow when deciding on medical treatment.

I first look at what is bothering them [meaning symptoms], and find out whether the illness is serious. When I have something in the house, I would first try and mix it around and give to the child. Sometimes we buy Disprin. Even though sometimes you give them Disprin, you can see when the child needs a doctor. So I would then try and see where to go. Traditional healers don't fail. But, if a traditional healer can't treat the illness, that's when I see I need to go to a Western doctor. When it fails, then I go and see a traditional healer. It's not every time that a traditional healer may fail on healing, but you will change them so often [try several different healers]. You would hear another person saying: "I was helped by this other traditional healer." And then I would take them to that traditional healer. There is always a traditional healer who will be able to heal that illness. [Lerato]

In the quotation above, Lerato discusses a familiar sequence in the decision-making process: an initial

assessment of the symptoms, dispensing medication at home, consulting a traditional healer, and, finally, going to Western doctors if the illness persists. Using Disprin is akin to acting in trial and error. If Disprin and home remedies fail to ease the illness, the research participant moves to a professional. Sometimes she needs to see a doctor, in which case she then makes a decision as to where to go (to a Western practitioner or a traditional healer). In the case of Lerato, she first seeks help from a traditional healer, and this selection of the traditional healer is influenced by other people's opinion, namely, those from her social network groups. Lerato's belief in the power of indigenous medicine is profound:

There is always a traditional healer who will be able to heal that illness. [Lerato]

This is also expressed in her determination to move from one healer to another to find help.

The Cultural Meaning of Illness

Another reason for seeking help from traditional healers rather than biomedical practitioners is related to the cause of the illness. If the illness is believed to be the result of supernatural intervention, then individuals are more likely to seek a traditional healer's help than that of a biomedical practitioner.

With my previous husband who passed away, the first thing he used to do is go to a traditional healer. Yes, I remember during those times when we were still at his family home in the 1990s. We used to go to this other women, who told him that he has *sejeso*

[food poisoning: witchcraft] and that he has pimples in his stomach. She told him he has *sejeso* and it's been there for a long time, even before me and him met. [Dineo]

Some people only prefer traditional medication when they feel that the illness is not too serious, but for severe illnesses they prefer a biomedical practitioner. In most cases, if the illness is experienced as being normal and even minor, then the caregiver prepares the remedy for the illness.

I go to the Batho chemist if I want those. They have traditional remedies available. I just go there and say I want this type of medication. I don't even know what it is, but I go looking for it. They give it to me, and tell me how to prepare it. You see, Bongani, he had a colic problem when he was still an infant. I told his mother to dab a little medication on top of his head, his palms, under his armpits, and just below his legs, before you take him anywhere with you. [Khomotso]

In most cases, the illness definition plays a big part in negotiating medical treatment. Traditional medication is often used to prevent bad spirits and to suppress supernatural causes of illness. Some research participants prefer mixing both traditional and biomedical treatments to heal illness. If an illness is considered to be normal and minor, then the research participants often revert to self-healing.

If they have stomach ache, as the mother, I am old now, so I will go to the chemist or mix vinegar, bicarbonate of soda, and sugar and give it to them to drink. [Ledisi]

I go to the hospital, when a child is really sick and I see he really needs a hospital. I go to a traditional healer, when a child is not sick. I do this so that when a child is walking outside, he's not attacked by bad spirits. But, if he is really sick, then I take him to the hospital. But, I don't like going to Pelonomi [Hospital] or the clinic. I usually go to a private doctor in town. [Khomotso]

Another thing is what type of illness is it. What was I crying about? Looking for the right medication for that illness and which corresponds with my beliefs. [Lerato]

As we can see from Lerato's remark, belief systems and past experiences, which reflect culture and tradition, often guide the treatment choice. Nomasonto explains in the following quotation how she comes from a household where the cause of an illness was always assigned to the supernatural (witchcraft).

My culture and medicine [laugh]...I grew up in a house of...if you are sick. My father is going to think: It's like Siphesihle crying at night: *Bamthakathile!* [Bewitched] *Abathakathi!* [Witches], you know [laughing]. But, I'm just ignoring it. I will just say: "Maybe it's something wrong. It's something. It's just a child, he cannot say where is the pain." My culture is witchcraft [laughing]. [Nomasonto]

Culture plays a prominent role in the research participants' treatment decisions. *Lengana* (Sagewood, see: <http://www.bioafrica.co.za/oils/artemisia.htm>) is known by African people as a cultural and traditional herbal plant that is used to treat many

illnesses. Drinking a liquid mixed with this plant is believed to have healing properties. Most of the research participants plant *lengana* in their backyards or collect it in the forest.

As I am a Sesotho parent. Any of my children, whatever illness they have, I take *lengana* and mix it with something and they will be healed. There are those that I can see that they are very serious. They need a doctor. [Dineo]

Medical Knowledge, Decisions, and Practices

To negotiate illness in a household that is already seriously constrained by poverty and deprivation adds a substantial burden on caregivers. From the narratives, it is clear that several research participants are driven by sheer desperation when having to deal with illness in the household. In many cases, a hit-or-miss strategy is inevitable.

I first look at the child. I look at the illness. It's so that when I have looked at the child, I have identified what is wrong with her. What is the illness and what would treat it. That is when I take a step. [Dineo]

It's like sometimes, when a child says he has a headache, I will just go to the shops and buy a Panado [pain relief], or Disprin [pain relief]. When they have flu, buy a flu medication. During those days, I would take Bostol [pain relief] and honey and mix them. It's flu medication. [Teboho]

Decisions are based on the interpretation of the illness, as well as on the meaning that the caregiver

constructs about what the symptoms of the illness represent. For some caregivers, the presence of blood is indicative of serious illness, and without blood an illness is often regarded as minor, and treatable by the touch of a traditional healer.

You see, right now the person...I take a person to the doctor who has been stabbed or when there is blood. And you don't know where the blood is coming from, right. So you have to take them to the doctor. Because these days blood is diseases, so you can be able to protect yourself. But, Itumeleng was just sick. But her, I took her to a traditional healer. I saw that she was...she had that devil's worshipper spirit. And that man prayed for her, and said I should get holy water and oil and make her drink it. So when we pray in this house, we pray every day, and now she is fine. [Khetiwe]

Khetiwe alludes here to another aspect of the health spectrum: violence and accidents. In terms of her criteria, the presence of blood means and represents the need for biomedical intervention. Something is wrong with the body. She also speaks of the need for extra care and protection when blood is involved because, "these days blood is diseases": this is a clear reference to HIV. After a caregiver has constructed the illness meaning, the next step is often to consult her social networks or therapy reference networks known as *dirati*, which are family, friends, church, neighbors, or community members. This is illustrated by Dineo and Teboho:

Yes! I do. The lady next door and my daughter are the people I usually exchange advices with. "Have you

ever given her this?" "Have you done this to her?" "Take this and give to her." [Dineo]

Yes! When my child is ill, I would go next door and the person would tell me to give them this. It will help them. [Teboho]

The advice that research participants might receive from their network groups is based on personal testimonials, knowledge, and understanding. The input from these social networks impacts on the health-seeking practices and decision-making processes of an individual as the members of the social networks might combine their individual experiences of illness and remedies and advise on treatment. The importance of social networks is illustrated in the following:

Well, the first person I call is my mom. Like she will know what to do. She will tell me to do this and to do that. [Lebohang]

Yo! I get very scared when someone is sick in the house. If they cry, I cry with them. Then I think: Let me call my neighbor. I ask my neighbors to come and help me because someone is sick. Then they come. Zuki is the person I usually call and she helps me. She comes with medication or whatever she thinks will work. Then she will give it to the child. [Khomotso]

I panic. But, luckily enough, my mother is here. That's why I'm saying we are starting to bond. That anger, I think it is decreasing. I see her importance because I didn't see it before as I focused on my grandmother. I rely on her that much. So I do feel like: Wow, we are starting to bond! [Phaphama]

Like when I take them [children] to doctors, but they don't get well. I go to *dirati* [therapy reference groups]. People would come and tell you that this person once had this very illness. So, go buy such a thing. [Mampho]

Experiencing a feeling of helplessness and desperation in the face of a loved one being ill opens a caregiver to asking for help, advice, and support. By sharing the anxiety and powerlessness when confronted by the suffering of someone in one's inner circle, a mother manages to pull through. Survival of an illness is not only the effect of medical care—often also the result of support.

The research participants consider the advice given by their network group when deciding on the treatment, indicating the essential role of these networks. In some cases, as illustrated by Dineo, participants attempt to cure an illness first by drawing on their own knowledge and remedies:

Yes! Certainly...But, the illness is the first thing I look at, before I ask for help. I look first at the illness and then I treat her/him with my own stuff...But, when I see it is persisting, I then ask for advice from them. [Dineo]

For some research participants, their choice of treatment is based on what they know and what they have seen as working for others and for themselves. The research participants' previous experiences also influence the decision-making process. The following quotations point to some of the factors they take into account when deciding on medical treatment:

You know, with me, when someone teaches me on which one [medication] works for which illness, that is how I decide.

When I was growing up, someone back home, or me, was ill. And I would be healed accordingly...I was healed by this type of medication. [Lerato]

Participants often experiment with medication in a process of trial and error. For example, if the *lengana* mixture does not help, the next remedy is tried.

I would go see a doctor, even though my spirit doesn't allow it...and my going to see a doctor is when traditional healers have failed. [Teboho]

If an illness persists, some individuals who use traditional medication might switch to biomedical treatment, and those who use biomedical treatment might revert to traditional healing practices or remedies. The following quotations illustrate some of the research participants' treatment approaches:

It's to know that this type of medication helps with that. So I am not a person who usually changes medication. I drink the medication that is given to me by a doctor that I know. That when I use their medication, I will see results. [Dimpho]

I first start by healing myself, and if I see that the illness still persists, I then go see a *sangoma*, and say: "Can you please help me here. I have this kind of problem. I have tried, but I can't treat it." When the *sangoma*...because traditional healers know the way traditional healers know. Because these medications

do not work the same. The traditional healer will give me the way the traditional healer gives me. And when the traditional healer has given me, I will try using them like that and see whether they can heal me and get well. If I don't get well, the traditional healer does not know how to heal. Maybe I should go see a doctor [Western doctor]. [Teboho]

I choose medication that I see and know [through her upbringing]. [Lerato]

It's because you believe it will help you. Right now, if my child had flu and I had *krustument* [a plant known to the African women, and it is used as a form of herbal medicine], and if I believe it will help my child, then the child will be healed. I used to heal my children with it. [Teboho]

You know what makes you decide? You know...it's like it's the time there was an ill person. You once saw what cured Happy [her grandchild]. So it comes back in your head, that thought comes back. You are going to buy that to help this person, yes...Someone once had this illness, and they drank such a thing. So let me go to find it for them because that other person: when they were ill, things were like this and that. So it helps. [Mampho]

The research participants' lived experiences, amidst different healthcare options, explain the fact that they encounter various barriers when negotiating medical treatment. Some of these barriers include: socio-economic status, the location where they live, their limited finances, their knowledge of health, and their cultural beliefs. On the practical level, the participants express a need to self-

treat because of the fact that medical care is often unattainable. The most prominent problems that research participants experience are therefore related to affordability, availability, accessibility, service, time, as well as the perceived quality of medical treatment.

Conclusion

Reality is experienced as being subjective, contextual, and temporal. The experience of illness is also subjective, contextual, and temporal. In addition, it also has an emotional impact leading to caregiver burden because of the uncertainty of the direction that the illness will take, the unpredictability of the implications of the illness, and the financial strain usually associated with sickness. Most research participants' narratives contain feelings of panic, fear, anxiety, and uncertainty related to the onset of an illness. This is a manifestation of the consequences that illness brings: cost of treatment, loss of income, and fear of harm and death. Findings from this study indicate that family, friends, social networks, and strong cultural beliefs influence women's explanations of and attitudes towards illness. Illness is constructed through particular lenses and, with the odd exception, few of

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the participants' accounts reflect on accidents, violence, and physical injuries as part of their illness narratives.

Illness experiences and the accompanying anxiety and stress often bring cohesion and solidarity. One of the key findings of this study is that most participants move between Western and traditional healing practices. All research participants experience deprivation and financial hardship. They have to deal with poverty in the household and they also face poor health facilities. Accounts of poverty and hardship are mixed as the narratives deal with illness, their lived suffering, and their struggle to survive from day to day.

The findings of this study demonstrate that the decision to engage with a particular medical remedy is influenced by a variety of socio-economic variables: the social status of women as caregivers; the type of illness; access to services; perceived quality of the service; the time of the day the illness occurs; seriousness of the illness; past experiences of illness; distrust in clinics; therapeutic/social networks (*dira-ti*); and their definition of illness. Women as caregivers often consult with one another in order to decide on what to do when experiencing illness.

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