

Frederick Golooba-Mutebi
Stephen M. Tollman

Shopping for Health: Affliction and Response in a South African Village

Abstract

Much research on health-seeking behaviour focuses on the influence of folk beliefs. The role of traditional practitioners and healing practices feature prominently. On the other hand, in thinking about service delivery in the health sector, policy experts working for governments and the development fraternity focus on physical infrastructure, supplies, equipment, and resources, human and financial, as the critical elements in ensuring quality provision by providers and consistent use by consumers. Folk beliefs about illness causation and treatment and how they may or may not influence service use do not feature in policy discussions. Nor are they a major feature of medical curricula. This paper shows, as does other evidence, that this approach to health education and policy making is inadequate. It addresses three questions. How do the people of Tiko respond to ill-health? What influences their health-seeking behaviour? What do their responses imply for public policy generally and health policy and practice in particular? It shows that, as elsewhere, response to ill-health is pragmatic and pluralistic. Folk beliefs are important in decision making. So are other factors, including experiences with the formal health system and access to social and financial resources. It shows that the search for therapy is not a powerless and blind search, but one based on rational decision-making, in which many actors participate. It adds to the evidence that building functioning health systems and delivering services that address users' needs demands more than technocratic fixes.

Introduction and background

Poor people in developing countries are burdened by ill-health (Narayan and Petesch, 2002), often the cause of their poverty. High HIV/AIDS prevalence and infection rates, as in South Africa, exacerbate suffering. Many factors influence people's response to ill-health, including entrenched beliefs (Greenfield, 1987; Sachs, 1989; de Zoysa, Bhandari, Akhtari & Bhan, 1998; Whyte, van der Geest & Hardon, 2002).

We examine responses to ill-health in a rural South African village and the ideas and reasons underlying them. The village, Tiko (fictitious name), is located in Limpopo Province. Its 3776 inhabitants include 926 Mozambican immigrants,¹ mostly 1980s war refugees. Both groups are of Shangaan identity. Due to cultural homogeneity, they share beliefs about illness and illness causation and exhibit similar health-seeking behaviour. In the case of illnesses the diagnosis and response of Mozambicans first 'found' in South Africa² are influenced by pre-existing folk knowledge within the host community.

Drawing on research in other contexts, we address three questions: how do the people of Tiko react to illness? Why do they react the way they do? What do the reactions and their justification imply for public policy in general and health policy and practice in particular? Our research reinforces findings elsewhere, particularly about pragmatism and plurality of response to ill-health. In addition to affirming and sometimes interrogating factors commonly cited as influencing health-seeking behaviour (Pronyk, Makhubele, Hargreaves, Tollman & Hausler, 2001; Hundt, Stuttaford & Ngoma, 2004) we highlight the role of users' encounters with providers, and of social networks. The influence of these factors has been amply explored in some contexts (Scheper-Hughes, 1992; Greenfield, *ibid.*), but not in South Africa.

Data collection

We draw on ethnographic material collected over 18 months.³ The large size of the predominantly South African sections of the village compelled us to design the study around a core group of informants experiencing poor health at the time, and those who, during earlier phases of the project, had been ill or care-givers. Interviews and informal exchanges identified more informants. We observed social-grant claimants on pension day and identified TB sufferers and stroke victims. For the smaller immigrant community, we convened a meeting to explain the research, and asked people to share their experiences with us and convey our request for interviews to those absent.

We conducted 55 in-depth interviews mostly with older adults and held informal discussions with other villagers of various ages. Respondents were mostly older adults. Although this focus seems to bias the research and poses questions about representativeness, it can be justified by young people's limited knowledge of complex illnesses, their causes, and therapy options. As the research progressed it became clear that older people chose therapy for members of their households or influenced their choices.

Affliction, diagnosis and response: Tiko in a wider context

Regardless of geographic or social context, ill-health is attributed to numerous causes. Some illnesses, including mild, easily treatable ones, those linked to old age and others common in young children, are attributed to God's will. Some, such as epilepsy and seizures, are attributed to ancestors or spirits, others to natural causes. Yet others, including protracted difficult-to-treat illnesses, are attributed to human agency: poisoning, witchcraft, or sorcery (Steen and Mazonde, 1999; Cumes, 2004; Janzen, 1978; Ngubane, 1977). Therapy choices are guided by knowledge of, or beliefs about, their relative efficacy. Elsewhere in South Africa (Ashforth, 2000; Niehaus, 2001), depending on the presumed cause of affliction and appropriate therapy, sufferers look to allopathic or traditional medicine. Villagers in Tiko share many of these beliefs and exhibit similar reactions. Besides beliefs, however, personal experience, rumour and material circumstances influence behaviour. Social and kin networks and the wider community are important sources of advice.

Therapy-seeking in Tiko: Diagnosis

Afflictions are divided into four broad categories and grouped according to cause and appropriate therapy. Illnesses such as malaria, the common cold (*mukuhlwana*) and

minor ailments are attributed to natural causes, hazards of everyday life that only God can explain. Others are attributed to eating particular types of especially processed food, or eating it too often and in large quantities: diabetes (*mavabye ya chukele*), hypertension (high blood), *ndatswa*,⁴ rheumatism (sugar, cooking oil, refined mielie meal, exotic chickens, and salt). Still others are attributed to pollution. Ritual pollution can result from failure to observe conventions governing particular rituals. It is said to cause *tindzaka* (with TB-like symptoms), *vukulu* (many forms of childhood physical disability), and HIV/AIDS whose symptoms and mode of transmission confuse people. TB, said to afflict miners and ex-miners, is attributed to pollution by dust. Its likeness to *tindzaka*, however, also confuses.

Some afflictions are attributed to human agency: witchcraft or 'feeding' (*xidyiso*). Huntingford (1963: 175) describes witchcraft as 'the power to kill or injure people by means of spells'. It is in this sense that the people of Tiko use the term.⁵ As elsewhere (Ferguson, 1999), witchcraft is believed to involve not only the use of spells but also poisons and other 'medicines'. *Xidyiso* is something that, once ingested, turns into a live organism that 'moves about' and eats the victim from inside the body. The ingesting can be physical, or occur through a dream. The most dreaded witchcraft-related affliction is *xifulana* or *xifula*, which manifests itself in stroke- and septicaemia-like symptoms, severe headache or stomach-ache, and bodily swellings and wounds. It 'attacks' when the intended victim jumps over or steps on 'medicines' laid along a path or at the entrance to a homestead by a witch. Like *jogu* among the Dagomba (Bierlich, 2000) and inner *lubanzi* among the Bakongo (Janzen, 1978), its treatment by hypodermic injection is said to lead to certain death.

The suspected cause of an illness guides the search for therapy, but there are exceptions. It is believed that, regardless of presumed cause, some afflictions such as *tindzaka*, *ndatswa* and *xifulana* are treatable only by traditional therapy. Some, such as TB and HIV/AIDS, are considered treatable by both traditional and allopathic therapy; others such as 'sugar diabetes' and 'high blood' only by biomedicine and do not respond to traditional therapy. Afflictions for which allopathic therapy is considered unsuitable are those attributed to ritual pollution and witchcraft, the latter being fairly common.

With few exceptions, chronic afflictions are attributed to human agency, but not always with complete certainty. Exceptions include diabetes, high-blood pressure, and *ndatswa*. The perceived connection between human agency and illness is evident from an informant's response when asked where her son was. He was at a traditional healer's because 'they made him run mad' (*va mu hlanganise engcondo*). A witch, she believed, was behind the affliction.

Within the village, information is widely exchanged about many matters, including health. Information sharing at times of illness is especially important. In Congo, Janzen (op cit: 4) found the role of kinsmen whom he called the 'therapy management group' significant. In Tiko this role extends beyond kin to include people who take an interest in a patient's well-being and volunteer advice. We call them the 'therapy reference group'. This phenomenon, hitherto unexplored in the literature, consists of friends, neighbours, and other contacts of the patient and wider family. Therapy referees suggest a diagnosis and advise on 'the best' sources of therapy, or about

practitioners who excel at treating particular afflictions. This advice influences decisions about therapy seeking.

Reaction to affliction

People react to illness in four ways: they do nothing and wait ‘to see what happens’; self-medicate; or visit clinics, hospitals, and traditional therapists. Responses are pragmatic and follow no particular pattern or sequence. As elsewhere (Steen and Mazonde, *ibid*; Bierlich, *ibid.*), depending on one’s circumstances and world view, reaction might involve one strategy or several, separately or simultaneously.

Waiting ‘to see what happens’

This happens when an illness is in its early stages or does not cause intolerable discomfort. The sufferer seeks to establish how serious it might be and hopes that it will go away by itself.

Self-medication

Usually the first line of defence, it entails the use of traditional and allopathic medicines separately or in combination. It is premised on the belief that a problem – cuts, fevers, colds, sores, headaches, and other minor ailments and injuries – is easily treatable and does not require specialist attention:

When I have a headache, I take a piece of those sacks that long ago they used to pack melie meal. I burn it and inhale the smoke. The headache will stop.

As elsewhere (Heald, 1999), self-medication focuses on the afflictions’ somatic features. Many people are knowledgeable about herbs and concoctions for treating specific afflictions. When members of a sufferer’s kin and social network believe they know the problem and that it is treatable using certain ‘medicines’ that are readily available in the local bushes or at home, they are prepared and administered. People also have knowledge of allopathic medicines and the illnesses they treat. If available over-the-counter they use them without reference to a specialist. Some obtain medicines from relatives and friends in the formal health system or within their social networks. During fieldwork, people asked about medicines for joint pains, heart palpitations and worm infestation. Some asked about the ‘proper’ use of medicines acquired through contacts.

Herbalists, healers, diviners and prophets

The literature assigns them the generic label ‘traditional healers’, a term which raises questions about what is traditional about so-called traditional medicine and healing practices. Leonard (2000: 93) usefully applies it to ‘rural health practitioners whose techniques resemble health practices that existed before the spread of “western” medicine into the rural areas’. He does ‘not imply that all traditional healers use herbal medicines, nor that no non-traditional healers use herbal medicines’ (*ibid*). He distinguishes traditional from non-traditional practitioners ‘by method of practice, not by types of medicine used’ (*ibid.*). We adopt the same usage.

People seek treatment from three types of traditional practitioner: herbalists (*magedle*); healers (*inyanga*); and diviners (*sangoma*). In practice some of their

functions overlap. Here we present ideal types as given by informants, for purposes of classification. *Magedle* are not necessarily formally trained; they acquire knowledge of herbs from healers either as patients or through apprenticeship. Apprenticeship can be with kin who inherited their knowledge. Some *magedle* buy medicines from specialists and practice healing as a business. Informants claimed there are 'hundreds' of them in the village and that some are crooks who dabble in witchcraft and claim powers they do not possess, in order to rip-off patients and 'buy themselves something to eat'. *Inyanga* are a notch higher than *magedle* and considered to be more powerful. To become one, a person must undergo formal training in diagnosis and healing, usually at the prompting of ancestral spirits. *Sangoma* are diviner-healers; they, too, are formally trained under the influence of ancestor spirits.

Ideally, as among the Zulu (Ngubane, *ibid*: 101), *sangoma* uncover the real cause and meaning of an affliction using the divinatory technique of 'throwing bones' (Cumes, *ibid*), while *inyanga* dispense treatment. In practice, however, there is little difference between them, with many combining divining and healing functions. This probably explains why writers (Cumes, *op cit.*) and even people in Tiko use the terms interchangeably. Besides traditional practitioners there are prophets (*maporofeti*). These are clerics or officials of charismatic churches whose healing techniques include prayer, rituals, and the use of allopathic medicines and other substances. Although their services are sought after by practising and non-practising Christians, they are particularly popular with churchgoers.

When an affliction fails to respond to self-medication but is judged not to warrant a trip to a *sangoma* or *inyanga*, herbalists are the second line of defence. People visit them to treat mild or non-life-threatening afflictions. Diviners and healers are the third line of defence, consulted about serious and life threatening afflictions or, within the limits of their knowledge, mysterious ones. This mirrors behaviour among the Gisu of Uganda who consult diviners 'only at times of acute personal crisis' and not 'for routine matters or to give advice more generally'. Diviners are 'are course of final resort', a sign that 'all other means have failed', and 'part of a desperate search to locate the source of misfortune' (Heald, *ibid*: 97). As elsewhere (Farmer, 1992, Abrahams, 1994; Offiong, 1991) attributing illness to witchcraft explains the search for those responsible in order to initiate counteractive action. Further, recourse to divination amounts to a 'special focusing on the nature of disease' and 'a shift from the somatic to the social, from the visible to the invisible' (Heald, *op cit*: 106).

For illnesses that require observation, prophets and traditional therapists provide residential facilities. Patients stay until after recovery or when the therapist or relatives no longer believe it possible. The patient is then taken home to die. The decision to give up is often forced by the need to minimise costs. If a patient dies in residence, cleansing rituals for the healer's premises must be paid for. In some instances, rather than give up, relatives opt for allopathic services, usually too late for treatment to be effective.

Allopathic services

Within the region almost every village has a clinic or access to one nearby. There are also health centres with wider coverage. Some people opt for self-medication first, while others use clinics or health centres, even for minor ailments. Going to allopathic practitioners, especially private ones, is easier for those with health insurance.

The public health system encourages visits to primary care facilities first and to hospitals only when referred by health personnel. Non-compliance renders patients liable to pay fees. Otherwise free treatment is guaranteed. Nonetheless, despite free treatment at clinics, some sufferers attend only after illnesses have escalated, sometimes with chances of successful treatment considerably diminished. They are then referred to hospital where some die shortly after admission. This is why hospitals represent 'places of death' in people's minds, especially the elderly, many of whom believe that, once admitted, 'no one comes out alive', and that, therefore, hospitals should be avoided.

Therapeutic choices

Choice of therapy is not always straightforward. Nor are therapies used in linear fashion. Therapy seeking is pragmatic, sometimes entailing simultaneous use of different therapies. If an affliction does not respond quickly, alternative diagnosis and treatment are sought, on grounds that the current therapist 'cannot manage'. In some cases switching is gradual, involving back-and-forth movement as patients shop around to maximise the potential of each type. Nonetheless, dissatisfaction, even over a short period, may lead to frustration and resignation. An informant with a longstanding nasal problem illustrates:

They said 'it is flu; take these pills'. I did not get well, so I decided not to go back. I saw that even if I went back, it wouldn't help. They don't give you good medicine. I decided to stay home.

As for traditional healers, he was tired of them as well:

They are expensive, those people. I don't want to go there. They give you useless medicine and then take your money and buy mielie meal.

Resignation, though, usually happens when an affliction is not accompanied by severe discomfort and can be tolerated. Many factors influence choice of response.

The nature and seriousness of an illness is one. The more serious an affliction appears, the speedier the reaction; perceived severity also influences type of therapy sought. An informant who dabbled in traditional medicine and whose eye had been surgically removed at a local hospital illustrates:

When you feel pains all over your body, we go and dig up some medicine and steam you to make you sweat. Then we wrap you in blankets so that the illness can come out ... Nothing really injured my eye. It just started; just like that. Some people said I had been bewitched, that it was *xifulana*. But I couldn't understand how or why. I hadn't quarrelled with anyone. Eish! The pain was unbearable! I discussed it with my wife. We decided to go straight to hospital. There was no time to look for traditional healers.

Alternatively, when an illness causes anxiety about its cause and progression, therapy is sought. The type sought depends on the supposed cause and, by extension, therapy believed to be effective. An informant, with an eye problem attributed to ritual pollution but untreated for years, eventually travelled to seek traditional treatment. During the interview, months after treatment, she said nothing had changed. She had not sought allopathic treatment, believing it was unsuitable. In-depth discussion pointed to possible hypertension. Besides an early ocular paralysis, she experienced night sweats and palpitations but showed little enthusiasm for our suggestion that she try allopathic therapy.

Distance: Distance is an important influence over whether or not to seek allopathic care. As an impediment it is especially significant for hospital care. Hospitals are far from the village and visiting entails paying for transport from meagre resources. Referrals from clinics may be deferred while alternatives are considered, until forced by escalation in suffering. Paradoxically, when traditional therapy is deemed necessary, distance diminishes in importance. People usually opt for non-local experts who do not know them personally, some operating from distant places. Informants justify this by arguing that expert healers do not necessarily live in the village. Also, as they are not plugged into the local rumour mill, confidentiality is guaranteed. Further, going to non-locals ensures that local ones do not bewitch people for financial gain. And divination is more likely to be accurate if the diviner has no access to personal information about patients. Conversely, access to rumours by locals raises doubts:

He is going to tell me lies. If you're from here, he is going to tell you lies They will make you fight with people. Someone from far away will tell me the truth.

Nonetheless, local experts have their uses, as the case of a young man treated successfully by a local *inyanga* for *xifulana* demonstrates. The treatment followed failure by tablets from a private doctor and medicines from two non-local *inyanga* to cure him. The local *inyanga*, who volunteered his services while visiting the patient's family as a friend, supplied the medicine the young man believes cured him.

Lack of drugs: South Africa has a relatively developed health-care system with facilities within easy reach of users. However, they are routinely short of medicines, especially for chronic illnesses, and do not satisfy demand. Some informants claimed to have visited clinics several times and found no medicines. Some were given only painkillers, even for illnesses they believed merited 'strong medicine'. The belief that clinics do not have medicines or that they have only weak ones discouraged visits especially for minor illnesses or those for which alternative treatment could be found.

Poverty: In Africa and the developing world (de Zoysa et al., 1998; Bierlich, *ibid*; Narayan and Petesch, 2002) access to health facilities is difficult for many and transport usually has to be paid for. Inability to pay becomes a barrier to access. Similarly, in Tiko seeking treatment may entail expenditure on transport. Poverty compels people to defer visits. In private clinics patients pay upfront or immediately after treatment; those without means do not go there. Although traditional therapy must be paid for, it is generally affordable, made so partly by therapists expecting payment only after recovery. Some healers ask for a deposit (*xichela mhuri*) but the amounts are usually symbolic. Nonetheless, traditional therapy is not necessarily cheap. Some therapists let clients decide how to pay: cash, goats, chickens, cattle. Others charge as much or even more than allopathic treatment would cost:

Inyanga don't ask for money before you are cured. When you get well, however, they say 'I want my cow'. That may mean 500 rands, or even 1000. But some ask for a cow of 100 rands. With modern doctors you pay for the medicine they give you. If it is 20 rands, you pay 20 rands. If it is 100 rands, that's what you pay. So, as you see, even *inyanga* can be expensive.

For some people, cost is a deterrent to seeking traditional therapy:

I have not been to a traditional healer in this country. I have not been there because traditional healers want money. In Mozambique I had people to pay for me. Now the only help I get is from clinics.

Things have not always been like this. Traditional medicine, we learned, has been invaded by greedy people who treat it as a business:

In the past healers were good. They never asked for much money. When one treated you and you got better, they would ask for two rands; that was the cow. These days, healers want real cows. We no longer have healers. They are all *tsotsis* (crooks) now.

When patients are kept under observation, upkeep has to be paid for; costs escalate. When a therapist is not within walking distance transport costs are high. Nonetheless, payment in instalments might mitigate the financial impact, and assistance can be sourced through kin and social networks. Consequently, although it influences response to illness and choice of provider, poverty alone neither always nor necessarily constitutes a barrier to treatment-seeking. There are, however, instances where patients, with or without assistance, cannot afford non-local specialists. Therefore, in Tiko as elsewhere, the very poor die of treatable illnesses because of poverty. The testimony of an informant with a grandson afflicted by tuberculosis shows poverty as an impediment to access:

They gave him treatment but it got finished. So when you want to go back, you need money. But I don't have money. What can I do?

Conduct of health workers. As elsewhere (Jewkes, Abrahams & Mvo, 1998) informants accused health workers of misconduct, citing neglect, rudeness and disrespect. One elderly man's experience was typical:

I can give an example of myself, the way I was once treated. You see, I am blind. They put me in a ward with people who can see. The nurses disappear at night. You want to go to the toilet; you need help. They can call them but they don't come ... Sometimes they say 'why don't you die; you are so old, why don't you die?'

Such misconduct discourages visits to particular facilities in favour of others within easy reach. Where only the clinic providing poor service is accessible, people visit only after exhausting other options. Even last resort visits may occur under duress: 'I did not want to go to hospital. They forced me, saying that if I didn't go, they would tie me up with a rope ... and take me there.'

Besides rude behaviour, neglect of patients' psychological needs influences therapy-seeking. Rather than reassure patients, some health workers are dismissive of their fears and concerns. HIV/AIDS sufferers are especially vulnerable. While nurses are local, they are trained in Western-oriented paradigms and institutions and, for the most part, seek to assert their modern identity and distance themselves from traditional beliefs and practices. While formal health systems are opening up to traditional medicine, the Western orientation remains dominant. According to a retired nurse,

People feel they don't get what they need. Traditional healers first throw bones. At the clinic they measure temperature and blood pressure. If a patient's leg is swollen, he expects you to tell him that it is *xifulana*. But at the clinic they just dress his leg. It does not make him happy.

Research elsewhere (Scheper-Hughes, *ibid*) shows that when allopathic therapists are not reassuring, people look to traditional practitioners for treatment and explanations that lessen fear and anxiety. In Tiko, one informant with an illness that caused his hands and feet to swell was referred to hospital without being told what might be wrong. At the hospital he was examined, given painkillers, and told to return home. He

subsequently switched to traditional therapy. It had no effect, but the healer's diagnosis boosted his morale. When his condition worsened, his relatives forced him to return to hospital. He was given painkillers and other medication which diminished neither his faith in the traditional healer, nor his scepticism about allopathic therapy. By the time he died he had been to hospital a few times, and still knew nothing about his illness. Doctors had conducted tests which he described in full, but had still not explained what was wrong with him. The suspense only aggravated his disaffection with the formal health system and the people who work in it.

There are grounds for doubting traditional practitioners' understanding of illness and its causes (Green, Zokwe & Dupree, 1995). Within the sufferers' scope of comprehension, however, their diagnoses make sense, as they are couched in shared cultural idioms. Allopathic practitioners on the other hand, do not involve patients in the treatment process, usually leaving their anxieties intact. Heald (op cit.102-103) illustrates:

... the doctor assesses the significance of the symptoms, gives a diagnosis and prescribes a remedy, or refers the patient to a hierarchy of specialists. Almost total credence is demanded of the patient ... The divinatory situation is essentially different in its power relationship. Here ... it is the client who is the arbiter of truth; it is a system where both clients and doctors share the same cultural idioms, the same assumptions about ... the cause of misfortune.

Leonard (op cit. 99) also points to neglect of patients' need for information. Of 450 consultations observed in Cameroon, in only 71 cases were patients given information about the diagnosis and medicine prescribed. In only 29 cases were patients told what to do to increase chances of recovery or avoid similar illnesses in future, something traditional practitioners commonly do (Caplan, *ibid.*). Thus the greater faith traditional practitioners enjoy.

Dissatisfaction with particular types of therapy: Dissatisfaction with a particular type of therapy leads to a search for alternatives. The change may be preceded by persistence with the unsatisfactory therapy in the hope that it will work. One informant, who believed he had tuberculosis but turned out to have asthma, used traditional medicines for over ten years while changing practitioners four times:

I began taking traditional medicine in 1990 until 2001. In 2001 I gave it up because I had seen that it wasn't helping me. I started using pills from the doctor.

Another person who initially believed he had *tindzaka* but turned out to have tuberculosis spent 'a long time' using medicines from two traditional healers. Experiencing little improvement after paying large sums of money, he eventually switched:

I thought it was *tindzaka*. I went to a traditional healer. He said it was *tindzaka*. Then I discovered that he couldn't manage; so I went to another one. He said it was *tindzaka*. But his medicine wasn't working. I decided to try the health centre because I saw that the illness was getting worse. I decided that it was better to try the health centre for some pills. The nurses referred me to hospital to see a doctor.

Some people switch from traditional to allopathic practice on the advice of traditional practitioners who have run out of ideas. Others may switch from allopathic to traditional on the advice of health workers who, despite their Western-oriented training, believe in its efficacy against 'African' afflictions. Still others combine

allopathic and traditional therapies because ‘one strengthens the other’. Some believe allopathic medicines are weak and ineffective on their own. The ‘weakness’ therefore justifies the search for traditional supplements or alternatives. When alternatives are believed to be effective while allopathic remedies are believed to have failed, faith in the latter is undermined. This happened when an informant was recommended for surgery following failure by allopathic medication to un-block his urinary tract. Before returning to hospital for the operation, a friend advised him to try a traditional healer. Within days the problem had resolved. He still reported to hospital to ‘prove to the doctors’ that their decision to ‘cut me open’ had been made in haste and was mistaken. The experience boosted his faith in traditional therapy and dimmed his view of allopathic medicine.

Beliefs about certain types of healing techniques: This point relates to the previous one. There are types of treatment that folk knowledge deems unsuitable for certain illnesses and that if used they are dangerous, or even fatal. ‘African’ diseases belong to this category. It is believed allopathic practitioners know little, if anything about them, and that, consequently, they cannot treat them. This view, by no means unique to Tiko (Janzen, op cit.), represents a fairly common scepticism towards allopathic medicine.

As elsewhere (Rasmussen, 2001), witchcraft is assigned a central aetiological role in illness causation and often invoked when illness or events are deemed serious or mysterious. One testimony illustrates:

When it started, I thought it was just an illness because it made me vomit. With time, however, my stomach started rumbling. I thought I had been bewitched, that it was *xidyiso*. Even my children believed it was *xidyiso*.

In such circumstances people choose traditional rather than allopathic treatment because witchcraft-related afflictions are generally considered incompatible with allopathic treatment, as are those linked to ritual pollution or violation of taboos. Nonetheless, some beliefs, shown by the testimony below by a respondent who had heard ‘stories’, are based on rumour and speculation:

At the clinic they don’t give you good medicine. Even those private doctors, when you go there, they want 100 rands. But they don’t give you good medicine. They want you to go back and then they ask for 80 rands. When you go back again, they ask for 60 rands. But the medicine they give you does nothing. For example, Dr. X has a beautiful building and he lets you watch television. But he knows nothing. I’d rather go to a diviner.

There are, however, illnesses believed treatable by both traditional and allopathic therapy. The decision about which to use then depends on a number of factors, including ease of access. But one approach may be preferred because of entrenched beliefs about its relative efficacy or suitability.

Religion and therapy: Churches usually condemn traditional therapists. Self-avowed born-again Christians claim not to believe in traditional therapy or to trust *inyanga* and *sangoma*. They claim to use only allopathic and prayer therapy, the latter dispensed at church. Those who admit to using traditional medicine outside church claim to consult only herbalists. Herbal medicines, they argue, do not compromise their religious values because they are not dispensed in shrines where healers and diviners confer with oracles and ancestral spirits. Christianity, however, does not necessarily erase the belief that there are illnesses that allopathic therapy ‘cannot manage’ and which can only be effectively treated by traditional therapy, sometimes of

the 'demonic' variety. Consequently, Christians stricken by them consult healers and diviners clandestinely. Those who have not yet suffered such misfortune admit to willingness to do the same should the need arise. Only one woman, newly born again and suffering from TB-related complications, said she would rather die:

It is better to die. It is better to die. I swear to God, I'd rather die. I'd rather go to church. But to a traditional healer? It is better to die. They ate my money. I will never go there again.

Her views had been shaped by past negative experience with traditional practitioners. She had spent 'a lot of money' on treatment that had not worked. She then received allopathic treatment, with positive results. Perhaps the best explanation for the gap between what self-avowed Christians say and do, and why people maintain a large repertoire of responses to affliction, comes from a TB patient who, for some time, had tried different therapies. He had been eclectic in his choices because 'when a person is sick, he will try anything to get better'.

Information sharing: Sharing information extends from diagnosis to identifying solutions. Many decisions such as where to go for treatment, or whether to go at all, are made on the basis of information, including rumours, acquired in this way. One rumour concerned doctors in public hospitals:

I trust only private doctors. Those in hospitals arrange with mortuary owners to kill patients. If they pay him 1000 rands do you think he won't kill more than 20 people to make money for himself? Don't you know it happens? Don't you know it? Me, I know it.

The case of a young man who discovered that one of his legs had swollen while he slept, illustrates the influence of information sharing on response. Some people suggested it was *xifulana* and volunteered names of traditional therapists. Others advised a trip to a clinic or hospital for 'proper' diagnosis. He went to a private clinic first. The doctor suspected diabetes. He referred him to a hospital for a fuller examination. Given earlier suggestions that it could be *xifulana* and his fear that by going to hospital he risked being treated by injection, he rejected the doctor's advice and returned home. Encouraged and sometimes accompanied by his father, he visited several traditional healers. His behaviour supports Janzen's view that ultimately 'the lay therapy manager retains the right to choose the therapist even after a consulting doctor – diviner – has made his diagnosis and recommended action' (Janzen, op cit.:130), and demonstrates the influence of therapy referees over patients and their therapy managers. Further evidence of the influence of therapy referees is provided by an informant who, when asked how he had known about the therapists from whom he sought treatment for supposed TB, eventually diagnosed as asthma, responded: 'it was my friends. When they saw how ill I was, they told me which healers to go to. But they didn't help'.

Also, when negative information circulates about particular services, similarly negative views are formed, which influence people's willingness to use them. This partly explains the negative attitudes elderly people hold about hospitals. They believe nurses are hostile and that they inject elderly people with dangerous substances to 'finish them off'. Since people 'are killed there', they fear going to hospitals:

We fear hospitals because we hear nurses do not like old people. I hear they ask old people whether they are not tired of living. They say there is little medicine and they want to keep it for the young. They ask why we don't want to leave the medicine for

young people. You know what that means. That's why we are afraid; it is better to stay here and die at home.

The belief that health workers harm rather than care for the elderly is not unique to Tiko (Scheper-Hughes, *ibid.*). Nonetheless, some fear hospitals and not allopathic therapy itself. Although reluctant to go to hospital, some were willing to submit to examination and treatment if 'doctors' visited them at home. One such informant feared going into hospitals for reasons she could not articulate:

I don't know why I fear hospitals. I don't know what I am afraid of. If you ask me why, I can't tell you. My entire life, I have not been to a hospital. Even pills, when I see them, I tremble. If I take them, I just vomit.

According to her daughter-in-law:

Some old people have ancestors who do not allow them to go to hospital. Like my mother-in-law, even if you show her pills, she begins to tremble. So we take it that her ancestors don't want her to go to hospital. Since childhood she has not been to a hospital. Even the hospital card she doesn't have it. Even when she is seriously ill, she does not go to hospital.

The age (group) of a sufferer: People generally take young children for allopathic and only rarely for traditional therapy. Several reasons account for this behaviour. When children are ill, they just cry; they lack the ability to express what they are suffering from. Parents or guardians cannot therefore diagnose the affliction, as they might for adults who are able to articulate their problem. Children have weak bodies that can be easily overcome by serious illness, hence the imperative to seek rapid diagnosis and treatment at a health facility. Quick reaction is considered especially necessary when a child cries incessantly or is visibly weak and unable to play or eat. Illnesses for which traditional therapy is sought are those believed to be 'African' or related to bewitchment. Nonetheless, people believe that children do not have personal enemies and thus are not targets of witchcraft.

Therefore, save for 'African' conditions such as sunken fontanelles, illness is almost always attributed to natural causes suitable for allopathic treatment. Only when this is judged to have failed and theories formulated about other causes such as ritual pollution or taboo violation by their parents, is traditional therapy sought. Traditional medicines are believed to be 'too strong' and potentially dangerous or fatal if given to very young children. Allopathic therapy is considered safer because medicines are manufactured specifically for children and dispensed in carefully determined quantities. Nonetheless, one informant had different reasons:

I am a traditional healer. If my child has flu, I take him to the clinic because the law tells us that there is medicine for children at the clinics. It is also because illnesses like flu and diarrhoea cannot be cured by traditional healers.

Therefore the age group of a patient is important. Notably where ritual pollution is believed to have occurred or taboos violated, the cause of resulting illness is straightforward, in which case the decision to visit traditional therapists is made easily. Conditions attributed to these causes include nearly all physical deformities and disability.

Lack of time: Lack of time, especially for women, is important. The imperative for treatment is weighed against the obligation to cook, look for firewood, fetch water,

work in the fields, and other chores. This prevents some women from seeking care for themselves and their children, especially for illnesses considered non-life threatening, including dermatological disorders and worm infestation. Sometimes serious afflictions such as malaria are reacted to with procrastination. Gender-specific barriers such as 'lack of time' become particularly important when people are referred to hospital. The three district hospitals serving the area are far from the village, and a visit there might entail a whole day away from home.

Discussion and conclusions

What do these findings say about health-seeking in Tiko? They affirm findings in other contexts that pragmatism and pluralism underlie health-seeking. They show that, as elsewhere, beliefs about illness and illness causation influence people's therapy choices. They show that alongside beliefs, experience with the formal health system, every-day events such as household chores, and poverty, are important influences. They affirm that decisions about therapy seeking and management are usually collective rather than individual, and that therapy management groups play a key role. They highlight the importance of therapy referees whose role in guiding therapy managers has not been explored by other research.

The most immediate implication is that there is more to planning service delivery than focusing on infrastructure and supplies. Even where these are available, folk ideas about aetiologies of disease prompt responses to affliction that point away from the formal health system. Its use and usefulness to the users for whom it is intended is thereby diminished. Also, users may be repelled by the way the formal system works. Strategies for building functioning health systems or improving delivery must therefore reach beyond infrastructure, supplies and skills, and examine how health systems interface with local users and function in practice.

This paper shows the imperative for Western-oriented health professionals to be sensitive to the beliefs and motivations of the public they aspire to serve and, consequently, to take their perceptions, needs, and demands into account. Chances of improving care and realising its benefits increase if patients' aspirations and expectations are understood, by reference to their ideas about illness. As Janzen (op cit: 191 & 192) points out, 'many symptoms and complaints can only be understood by grasping concepts latent in a culture and in conditions affecting sufferers'. While people may accept and appreciate the 'unique competence' (Janzen, op cit:223) of Western medicine, the enduring importance of traditional therapies is captured by the pragmatism and pluralism service users exhibit as they 'shop around' for different therapies. The need for sensitivity to users' beliefs and motivations is particularly urgent where HIV/AIDS infection rates are rising. Making the formal system attractive and responsive to users can only enhance the effectiveness of facility-based strategies for checking the pandemic.

Testimonies about the conduct of health personnel suggest that supervision is inadequate. It is possible, however, that as elsewhere (Jewkes et al., *ibid*) reasons for misconduct go beyond lapses in supervision. A limitation of this study is that health personnel were not systematically interviewed. Such research would provide deeper insights into the workings of the health system and how delivery could be enhanced. Users' testimonies show that efforts to improve delivery must take into account the

supply and demand side of the system. Moreover, studies in other contexts (Tendler, 1997; Golooba-Mutebi, 2005) show that lapses in supervision lead to weaknesses in performance and, consequently, alienation of service users. Strengthening regulatory and supervisory or support functions should boost the quality of services and, consequently, user confidence.

Our findings question the common assumption that traditional therapy is cheaper than allopathic. Although important, cost of care is only one of many factors that influence therapy-seeking behaviour. When faced with life-threatening afflictions requiring traditional therapy, people go to great length, often at great expense, to locate a reputable practitioner. On the other hand, citing lack of money, they procrastinate about going to hospital. As a barrier to access, therefore, the relative importance of cost depends on context. Method of payment, the nature of an affliction and how it is understood within a cultural setting, experience of the formal health system and second-hand information, may be as significant as cost of care. The role of everyday activities and events points to the imperative for bringing services closer to users. Many informants recall the ‘good old days’ of mobile clinics that used to bring services to the village, and when nurses made home visits.

Beliefs about afflictions, their causes and suitable treatment suggest a need for context-appropriate education about diagnosis and treatment of common illnesses – tuberculosis, stroke, diabetes and high blood pressure – and various infections that lead to physical impairment because of inappropriate or inadequate treatment. Such education should diminish exposure to quack traditional therapists. The story of an immigrant woman with a tapeworm infestation, untreated for a long time, supports this reasoning. She believed that passing bits and pieces of the worms in her stool was evidence of possible bewitchment (*xidyiso*). Further discussion revealed that one of her grandchildren had an advanced infestation of ascaris worms. Our suggestion that she seek allopathic treatment for herself and her granddaughter was a revelation. It should not have been.

Notes

1. Agincourt Health and Population Unit: 2003 census.
2. They include HIV/AIDS (*ma-egisi*) and high-blood pressure (high blood) diabetes (*mavabye ya chukele*).
3. The research, conducted during 2001/02, focused on ‘household structure and wellbeing of Mozambican immigrants and their South African hosts’.
4. Burning sensation in the feet, accompanied by ‘black dots’ on the soles.
5. When speaking English they use ‘witchcraft’ for the Shangaan word *vuloyi*, and ‘witch’ for *noyi*.

References

- Abrahams, R., ed., 1994, *Witchcraft in Contemporary Tanzania*, Cambridge: African Studies Centre.
- Ashforth, A., 2000, *Madumo: A Man Bewitched*, Cape Town: David Phillip Publishers.
- Bierlich, B., 2000, ‘Injections and the Fear of Death: An Essay on the Limits of Biomedicine among the Dagomba of Northern Ghana’, *Social Science and Medicine*, 50, 703-713.

- Caplan, P., 1997, *African Voices, African Lives. Personal Narratives from a Swahili Village*, London & New York: Routledge.
- Cumes, D. M., 2004, *Africa in My Bones: A Surgeon's Odyssey into the Spirit World of African Healing*, Claremont: New Africa Books.
- De Zoysa, I., N. Bhandari, N. Akhtari & M. K. Bhan, 1998, 'Careseeking for Illness in Young Infants in an Urban Slum in India', *Social Science and Medicine*, 47 (12), 2101-2111.
- Farmer, P., 1992, *AIDS and Accusation: Haiti and the Geography of Blame*, Berkeley: University of California Press.
- Ferguson, J., 1999, *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt*, Berkeley, LA. & London: University of California Press.
- Golooba-Mutebi, F., 2005, 'When Popular Participation Won't Improve Service Provision: Primary Health Care in Uganda', *Development Policy Review*, 23 (2): 165-182.
- Green, E. C., B. Zokwe & J. D. Dupree, 1995, 'The Experience of an AIDS Prevention Program Focused on South African Traditional Healers', *Social Science and Medicine*, 40 (4), 503-515.
- Greenfield, S. M., 1987, 'The Return of Dr. Fritz: Spiritist Healing and Patronage Networks in Urban Brazil', *Social Science and Medicine*, 24 (12), 1095-1108.
- Heald, S., 1999, *Manhood and Morality: Sex, Violence and Ritual in Gisu Society*, London and New York: Routledge.
- Hundt, G. L., M. Stuttaford & B. Ngoma, 2004, 'The Social Diagnostics of Stroke Like Symptoms: Healers, Doctors and Prophets in Agincourt, Limpopo Province, South Africa', *Journal of Biosocial Sciences*, 36, 433-443.
- Huntingford, G. W. B., 1963, 'Nandi Witchcraft', in Middleton J & E. H. Winter, eds., *Witchcraft and Sorcery in East Africa*, London: Routledge & Kegan Paul.
- Janzen, J. M. with M. D. Arkininstall, 1978, *The Quest for Therapy in Lower Zaire*, Berkeley, Los Angeles, London: University of California Press.
- Jewkes, R., N. Abrahams & Z. Mvo, 1998, 'Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services', *Social Science and Medicine*, 47 (11), 1781-1795.
- Leonard, K. L., 2000, 'Incentives in Rural Healthcare Delivery: Cameroon I', in Leonard, D. K., ed., *Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues*, London: Macmillan Press Ltd.
- Narayan, D. & P. Petesch, eds., 2002, *Voices of the Poor: From Many Lands*, Washington, DC: The World Bank & New York: Oxford University Press.
- Ngubane, H., 1977, *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyuswa-Zulu Thought and Practice*, London: Academic Press.
- Niehaus, I., 2001, *Witchcraft, Power and Politics: Exploring the Occult in the South African Lowveld*, London: Pluto Press/Capetown: David Philip.
- Offiong, D. A., 1991, *Witchcraft, Sorcery, Magic and Social Order among the Ibibio of Nigeria*, Lagos: Fourth Dimension Publishers.
- Pronyk, P. M., M. B. Makhubele, J. R. Hargreaves, S. M. Tollman & H. P. Hausler, 2001, 'Assessing Health Seeking Behaviour among Tuberculosis Patients in Rural South Africa', *International Journal of Tuberculosis and Lung Disease*, 5 (7), 1-9.
- Rasmussen, S., 2001, *Healing in Community: Medicine, Contested Terrains, and Cultural Encounters among the Tuareg*, London: Bergin and Garvey.
- Sachs, L., 1989, 'Misunderstanding as Therapy: Doctors, Patients and Medicines in a Rural Clinic in Sri Lanka', *Culture, Medicine and Psychiatry*, 13, 335-349.

-
- Scheper-Hughes, N., 1992, *Death Without Weeping. The Violence of Everyday Life in Brazil*, Berkeley, Los Angeles & London: University of California Press.
- Steen, T. W. & G. N. Mazonde, 1999, 'Ngaka ya Setswana, Ngaka ya Sekgoa or Both? Health Seeking Behaviour in Batswana with Pulmonary Tuberculosis', *Social Science and Medicine* 48, 163-172.
- Tendler, J., 1997, *Good Government in the Tropics*, London & Baltimore: Johns Hopkins University Press.
- Whyte, S. R., S. van der Geest & A. Hardon, 2002, *Social Lives of Medicines*, Cambridge: Cambridge University Press.

Frederick Golooba-Mutebi
Stephen M. Tollman