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The Cultural Construction of Illness amongst *isi*Zulu-speaking Nurses: Probing Nurses' Understanding of Patient's Illness and Health in Hospitals

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DEDICATION

To the many people who have died, physically, spiritually and emotionally due to different forms of medical negligence and lack of respect for their wholeness, may you find life in full and live as complete beings.

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I present my great appreciation to the Almighty God for bestowing so much grace and love on me even when I do not see, know or understand how these blessings flow to me. For being ahead of me every day Lord, thank you.

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ABSTRACT

This study attempts to understand how cultural constructions of illness amongst *isi*Zulu-speaking nurses shape their understanding of health, illness and patient care. The study thus takes as a backdrop, the idea that people's views of the world and daily phenomena are shaped by their cultural practices and beliefs.

The study was qualitative and ethnographic and was carried out at a public hospital in the Durban area. It involved 20 participants and the data was collected through in-depth participant observation and semi-structured interviews. A unique feature of the study was that some of the participants were both trained biomedical nurses as well as practicing *izangoma*.

The findings of the study show that the *isi*Zulu-speaking nurses' understandings of health and illness have been shaped by their cultural constructions of health and illness. Aside from their nursing training, i*si*Zulu-speaking nurses' understanding of health and illness is likewise understood as being in part, shaped by and embedded in their cultural practices and beliefs such as bewitchment and ancestry curse. These cultural constructions and understandings in turn influence their clinical decisions and patient care. The research findings reveal that the *isi*Zulu-speaking nurses involved in the study face levels of internal conflict in carrying out clinical decisions. Such a conflict was deeply expressed by the nurses; especially the *isangoma* nurses who felt that their twin expertise as traditional practitioners and nurses places them in a better position to understand '*how'* to care for patients, against the care prescribed by the hospital. This difficulty faced by the nurses is informed by the sometimes conflicting and contested expectations on them as biomedical personnel against their own culturally embedded understanding of health, illness, and patient care.

Keywords/phrases: *isi*Zulu-speaking nurses; *isangoma,* cultural constructions; biomedicine, health and illness; clinical decision

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CHAPTER ONE

Introduction and Literature Review

1.1 Preamble: South African Public Health - An Overview

Living, as a process of existence, is "a continual interplay between the individual and his [sic] environment, often taking the form of a struggle resulting in injury or disease" (Dubos 1987: 1-2). What then is health? One may ask. Although there is no standard definition of what health is, but using Dubos' (1987: 3) definition, health can be regarded as the lack of absence of sickness in a being, thus leading to physical, psychological and social state of wellbeing.

Sickness, on the other hand, is defined by an American epidemiologist and anthropologist as the those conditions of self that are unwanted or are of some level of threat to a being (Hahn 1995: 22). Sickness is thus an inclusive term that covers both diseases and illnesses. According to Brown, Barrett and Padilla (2005: 11), disease can be referred to as "the outward, clinical manifestation of altered physical suction or infection". This definition is based on the view of a person's state of health as "a clinical phenomenon, defined by the pathophysiology of certain tissues within the human organism" (Brown *et al.* 2005: 11). Illness, however, is made up of the experiences of the person and his or her perceptions of health alterations as shaped by his or her social and cultural meanings (Brown *et al.* 2005: 11; Chigona, Glen, Stam, Stam, Van Belle and Wu 2008: 2; Naidu 2014: 149; Parle 2003: 108; Richter 2003: 5). The two notions of illnesses and diseases are experienced in all societies, and each society has its approach to either of these or both.

There are many recognised illnesses and diseases within the South African society. Some of these are malaria, *umtshopi*, typhoid, *idliso*, *imbande*, stroke, cancer, diabetes mellitus, hepatitis, HIV/AIDS, and many others. Of these illnesses and diseases, studies (see Human Sciences Research Council – HSRC 2002; Hunter 2003: 689; Joint United Nations Programme on HIV/AIDS – UNAIDS 2002) have shown that HIV/AIDS is the most dominant sickness in the country as the country's number of 'People Living with HIV/AIDS' (PLWHA) is the highest compared to any country in the world. The prevalence of HIV/AIDS

in the country is around "11.4 per cent to 20.1 per cent" (UNAIDS 2002).[1] Tuberculosis (TB), although closely linked to HIV/AIDS, is another major illness challenging the South African society and health system. Badri, Wilson and Wood (2002: 2064) in their study on the "Effect of Highly Active Antiretroviral Therapy on Incidence of Tuberculosis in South Africa" show that tuberculosis is one of the leading causes of morbidity and mortality faced by HIV-1 infected patients. Another illness within the South African society that is less formally recognized but contributes to the deteriorating state of public health is *idliso* and other culturally-understood illnesses. According to Wilkinson, Gcabase and Lurie (1999: 840), "*idliso* is reported to be 'man-made', and the illness is said to be causally traced to a person mixing traditional medicine[2] ('*muti'*) with a 'victim's' food, in order to poison or bewitch him [sic]". *Idliso* can be categorised as an illness because it is informed by broader social and cultural meanings and mainly curable by traditional African medicine.

Different approaches may be applied in dealing with sicknesses within societies. South Africa, as it is today, has the benefit of having a pluralistic system of health provision (Wreford 2005: 55). The most dominant approaches, however, as shown by studies (see Kirsten, Van Der Walt and Viljoen 2009: 1-2; Wreford 2005: 55), are the traditional approach, biomedical, and spiritual approach. Each of these approaches has some level of impact on people. However, the impact of each depends on the dominant ideology that enlightens and guides the conduct of those who use it. Of these three approaches, traditional medicine and healers are well prominent and patronised (Wreford 2005: 55; Keetan 2004: 4)

After the 1994 independence of South Africa, there was the introduction of a White Paper to contribute to the transformation needed in the country's health system. In this paper, traditional medicine and healers were recognised as great contributors to public health care in the country. After this recognition step in the country's health system, 2004 saw the introduction of the "Traditional Health Practitioners' Bill". This Bill recognized the "unique

[1] The period between 1990 and 2005 saw a shocking rise in South Africa's HIV prevalence rate from less than 1% to around 29% (Hunter 2003: 689). It was reported by the Word Health Organisation (WHO) that there were 1,600 new daily cases of HIV infections the country (WHO, 2002). Thus, one can infer that there are approximately 584,000 new infections every year in the country.

[2] Traditional medicine has been defined by the World Health Organisation as "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses and maintain well-being" (WHO 2001).

circumstances of traditional healers, sets professional and ethical" standards for traditional healers and practitioners while at the same time empowering their practice (Ross 2007: 17). These recognitions, however, can be said to have rather theoretical as traditional healers are still not trusted despite the overt role they play in the country's health care. As stated in the 2004 Traditional Health Practitioners' Bill, traditional healers were required to register with a statutory body and were strictly supervised against any malpractice. This acknowledgement of the possible role of traditional healers and medicine in health care was in accordance with an earlier proposition made by World Health Organization (WHO). The WHO had suggested that social and technical training are to be given to traditional healers so that they can be fully engaged in primary health care within the traditional healers' communities (Felhaber and Mayeng 1997). The presence of about 250, 000 traditional practitioners in comparison to the 23,000 medical doctors registered in the country shows the level of involvement South African traditional healers have in health care giving (Keetan 2004: 4). There is, however an unwavering relationship between traditional medicine and healers with biomedicine and practitioners. Traditional medicine uses spiritual methods of healing as against the "lab-tested" method used by biomedicine, thus, partly explaining why the two systems most times operate at arm's length or at parallel positions. Such a state of health approach, however, poses challenges and limits the efforts of promoting a healthy society. This limitation contributes to what some authors (see Chopra, Lawn, Danders, Barron, Karim, Bradshaw, Jewkes, Karim, Fisher, Mayosi, Tollman, Churchyard and Coovadia 2009: 1030; Coovadia, Jewkes, Barron, Sanders and McIntyre 2009: 817) regard as the "dysfunctional" state of the country's health system.

According to Coovadia *et al.* (2009: 817), South Africa's health system is in a dysfunctional state. This 'dysfunctional' state, they claim, has its roots in the country's historical policies dated back to its colonial, apartheid and post-apartheid era. The country today, they assert, is a portrait of the effects of social factors, economic, political and cultural, on people's health and state of living (Coovadia *et al.* 2009: 817). This standpoint has also been asserted by Chopra *et al.* (2009: 1030) when they stated that the "historical legacy of disruptive and forced human movements, alcohol abuse, sexual risk taking, sexual violence, and patriarchal ideals of masculinity…, risk taking, control of women, and willingness to use violence to defend honour – has left millions of people exposed to many, often severe health risks". Unfortunately, the aforementioned circumstances remain the most or only considered

circumstances looked at when dealing with health issues in the country. The impact and influence of the cultural understanding and approach to health on nurses' clinical decisions and patient care has, to a large extent, been given little or no recognition within the 'formal' health system and policies. However, the possible impact of one's society, its cultural practices and beliefs can go a long way in determining the understanding a person has of health, health-related behaviours, and how he or she administers or receives any healing process.

1.2 Survey of Existing Research

Based on constructed and promoted health policies, as found in the Millennium Development Goals, the South African health sector emphasised the link of illness to social, political, economic and biological causes and how that can be tackled (Chopra *et al*. 2009: 1024). The two major goals state that:

> Priority health programmes should no longer receive the majority of attention and resources... More resources will need to be deliberately and carefully allocated to allow manager at all levels to provide stewardship and leadership to integrate a range of programmes within a specific health setting"… Secondly, the "Department of Health will need to proactively engage with regulatory authorities and (biomedical) training institutes to accelerate the qualification of doctors, nurses, and mid-level workers, and broaden their professional abilities for implementing of an expanded range of services at the district and primary levels (Chopra *et al*. 2009: 1029-1030).

These sets of priorities have implications on how the Department of Health functions. They do not, arguably, give room for understanding or making use of the local, traditional, understandings of health and illnesses despite the Traditional Health Practitioners' Bill of 2004 (see Matomela 2004; Ross 2007: 17-18). This call for the due recognition of traditional healing process and system as practiced within the country was based on its visible impact on people's attitude and understanding towards health and illness. The Millennium Development Goals, however, ignored the motivations behind the Health Practitioners Bill and the understanding that one's environment, is unhealthy, the person's wellbeing is also affected (Kirsten *et al.* 2009: 4), a belief that is at the heart of both eco-systemic anthropology and

traditional medicine. It is a belief which rests on the notion that for a person to be well there needs to be a healthy environment in which he or she lives in. This environment is a combination of the people, the natural environment, and the spiritual realm. A 'dysfunction' in any of these environments can bring a misbalance in a person's health, claim Kirsten *et al*. (2009: 6). A dysfunction within a person's environment is able to cause misbalance within the person's health because we are made up of both internal and external elements, which affect our state of being.

Thus, in order for a person to be in a constant state wellbeing, there ought to be a balance in these worlds as the bio-psycho-spiritual health of a person is strongly bound to his or her environment, both physical and symbolic (Kirsten *et al.* 2009: 5). This belief about health and wellness is strongly held in many African societies. It is believed that the beliefs surrounding traditional medicine and health is similar in many African communities and in South Africa (see Setswe 1999: 56). The belief attributes illnesses to supernatural phenomena that are based on a hierarchy of powers. According to this belief, there exists "a ruling deity, less powerful spiritual entities, ancestral spirits, living persons, animals, plants and other objects in that order" (Truter 2007: 57). The *ama*Zulu, like many other African societies, have similar conceptions of society, health and illness (Parle 2003: 107). As such, illnesses amongst such African societies are attributed to spiritual or social causes and not only physiological or biological causes (see Naidu and Ngqila 2013: 128). The construction and understanding of health and illness amongst *ama*Zulu is greatly influenced by this belief. Thus, the practice of any form of humanistic profession, such as medicine and healing, especially within an *isi*Zul-speaking people's locale, needs to take into consideration the religio-cultural situatedness and location of such a practice.

The African view of health and illness allows for an approach to health from a variety of cultural paradigms and promotes what is known as ethnomedical approach in medical anthropology. Ethnomedicine is defined by Rubel and Hass (1996: 113) as beliefs and practices that have emerged from indigenous cultural development of a people and not from what is known as 'modern' (my emphasis)" medicine. It also enables us to bypass the monolithic understanding of the human person and illness as a thing of either the mind only, body only or spirit only, a tendency "inherited through Western biomedical models of approaching illness" (Parle 2003: 108). Rather, it leads us to a more open and wider

contextualization of ill people and the condition they suffer from, and benefits from the holistic approach used in traditional African medicine. In this approach, the healers work on the person as a 'complete being', mind, body and spirit, and render psychological, physical, spiritual and social assessment and healing from the supernatural sphere (Truter 2007: 58). This speaks to a bio-psychosocial perspective of health and the body.

The bio-psychosocial model springs from an eco-systemic view of health, and is underpinned by two assumptions. The first assumption states: "the human being is a whole, a complete person of whom certain attributes can be distinguished but never separated" (Kirsten *et al.* 2009: 4). Such a view disallows the reduction in understanding of health to just the "absence of disease", either in a person's mind (psychological) or the physical body. Rather, it gives room for a holistic understanding of the human person and of phenomena that engulfs him or her, such as ill-health. The second assumption states: in approaching a person's health, multi-disciplinary as well as multi-dimensional approaches are to be implored (Robinson and Jones 2006: 1030). This second assumption connotes the ideas embedded in the views of critical medical anthropologists in their description of how different factors such as economic, political and social, can hinder or influence a person's social behaviour and thus increase their susceptibility to diseases (Brown *et al.* 2005: 15). Both assumptions evade the Cartesian dualism which has been promoted from antiquity in many disciplinary and religious paradigms until the beginnings of the 20th century. The duality which was initiated by Rene Descartes, a 16th century French philosopher, states that *cogito ergo sum* – "I think therefore I am", thereby making the human person a *res cogitans* - "thinking thing" (Descartes 1641). Cartesian views thus bred the duality of the human person into body and a soul, and each to be treated independently rather than in unison, with the soul being superior over other aspects of the human person (Copleston 1958: 93).

The new realisation of the need to treat the human person as a whole rather than in parts or based on the Cartesian dualism brought about the concept of 'psychobiology' (Dewsbury 1991:198-199) and the 'holistic bio-psychosocial model' propounded by Engles (Colman 2009: 92; Jordaan and Jordaan 2000: 554). These concepts and approaches to the human person can aid us in exploring the interactions between a person's social, psychological, biological and cultural phenomena and how those affect his or her health and approach to health and illnesses (Jordaan and Jordaan 2000: 227). The cultural aspect of the human person, which involves the spiritual realm, enlarges the scope of the bio-psychosocial model

to health and reduces limitations that sticking to only that model may brew as stated by Valenkamp and Van der Walt (2006: 11-12).

As Rosaldo (2003: 583) stated, we approach reality from our point of view. Our point of view, otherwise known as our 'worldview' or positioning has been constructed mainly through our interaction with society. Thus, as Creswell (2009:8) puts it, our prevailing worldviews are a result of the dialogue between us and our society. The understanding of illness 'followed' by nurses in the hospitals, such as the hospital that this study was carried out at, is mainly in line with the norms and practice of Western approach to medicine, health and illness. This practice has emerged in the wake of the contemporary globalization of biomedicine otherwise known as "biomedical imperialism"[3] (Macleod and Lewis 1988: 2) and the Western approach to health and illness.

According to Nustad (2003: 7), globalisation is the interaction between a "distinct realm of reality with another part of reality", with the 'distinct' having the ability of influencing and transforming the 'other'. The distinct reality in this instance is Western biomedicine, or what World Health Organization (1983: 126) called the "bio-medical model", which is practiced in other non-Western and "non-medical societies", thereby signifying the globalisation of biomedicine. This "othering" of non-Western societies was also raised by Stauss (2000: 11) when he noted that many Western societies use graphic representation to view the HIV/AIDS pandemic in Africa as an exploded reality that makes the continent the "other" continent to be used as a case study. According to Wade and Halligan (2004: 1398), biomedicine is based on three assumptions. Firstly, it regards all illnesses as emanating from a single cause. Secondly, it believes that disease or pathology is the single cause. Thirdly, it holds that removing the disease from a person will lead to stability in the person's health. This view and approach to health and illness forms the bases of biomedicine which has its origins from Europe and has continued to be maintained in its original format and understanding of health and illness (Finkler 2000; 2004: 2048). This understanding of health has been diffused to non-European societies through the influence of colonization and globalization of biomedicine, otherwise termed "biomedical imperialism" (Macleod and Lewis 1988: 2). It is this early biomedical

[3]Medical imperialism can be defined as "the extension of what has been called the 'bio-medical' model to the non-medical world" (WHO 1983: 126).

understanding and approach to health and illnesses that is still practiced at the hospital this study was carried out at.

It has been suggested by Capra (1982: 336) that biomedicine seems to have lost tract of using a holistic approach to healing whereby the patient's realities are taken into consideration in diagnosing him or her. This is because biomedical doctors gain more reputation as specialist of body parts rather than the whole person (Capra 1982: 346). For example, he says if asked about the causes of illness, biomedical doctors will refer to bacteria and physiological disorders. They, according to Capra, do not make practical efforts to understand and handle psychological and social aspects of patients' illnesses therapeutically" (Capra 1982: 348). Thus, biomedicine, *per se*, may be regarded as being inconsistent with the traditional view of illness from the perspective of a disharmony and imbalance in nature and to be best understood culturally (Kirsten 2009: 1).

Kleinman and Benson (2006: 1673) however, state that it is imperative for cultural factors to be considered when diagnosing and treating patients as such factors contribute in shaping the patients' health believes and values. The beliefs of a locale are intrinsic in the conduct and practice of any health care or delivery. This is so because, as asserted by Tomlinson (1999: 26), "globalisation is not a 'one-way' act of determining events and occurrences by "massive global structures"; rather, it "involves at least the possibility for local intervention in global processes". As such, biomedicine or Western medicine, should not and cannot determining the health practice of local communities without the health-related beliefs of local communities playing a role in how they react to such a global practice. As Finkler stated, "now the task becomes that of assessing" how health care practitioners explanation of aetiology[4] and patients care is being influenced and affected by their local cultural constructions of health and illness (Finkler 2004: 2037).

Nurses can possibly be caught up "between two worlds: the world of technological medicine, that symbolizes modernism, and the realities of a developing nation whose patients and doctors hold traditional and popular understanding of illness that requires simple technologies to alleviate the most prevalent diseases" (Finkler 2004: 2048). They have a professional and recognized identity as nurses, trained in the so called Western approach to the body and

[4] This is the study and understanding of illnesses from their causal state, definitions and thus lead to an understanding of their destructive capability (Steurer 2006: 85)

medicine, yet they also carry with them an understanding of health and illness from their Zulu cultural perspective. Their knowledge and belief in the Zulu understanding of health and illness can possibly bring about a conflict of role, interest, and ideas regarding the people that utilize the hospital spaces. Relatively less research, however has explored this possible aspect.

As Naidu (2012: 78) noted, there have indeed been recent works in the social sciences, which have alluded to the limitations of 'traditional'[5] medicine in understanding and dealing with illnesses and patient care. Twigg (2002: 426), for example, stated that in the modern world, especially in biomedicine, the "body becomes an object for scientific enquiry, to be studied in terms of scientific causality", thereby depersonalising the body from the experienced person. As such, the hospital becomes, for many people "an alienating experience in which the loss of sense of self that comes with the weakness of the body in illness is compounded by hospital practices" (Twigg 2002: 426). As such, biomedicine has lost trust from many people because people "prefer confidence in the reliable, fair, consistent and competent provision of services" (Harrison and Smith 2004: 379) rather than alienating approaches that disseminate them into body parts.

It is a possibility that many patients in hospitals, as those in Naidu's (2012) study, share similar views regarding the non-holistic approach of Western medicine to patient care. Such a non-holistic approach to patient care is possibly due to the hegemony embedded within the so called Western approach to medicine. However, taking good note of the "experience and meaning, listening" and "understanding the patients' concepts of bodily (and mental and spiritual) function may also be critical to treatment" (Weiss 2001: 7) as it will yield a more holistic treatment of the person. At the heart of the *ama*Zulu's approach to illness, healing is cultural, and entangled with religious beliefs, otherwise known as culture-religio beliefs, which are holistic in nature. This perspective does not restrict the focus of patient healing to only physical conditions; rather, it also looks at different aspects of the human person which involve his or her psycho-social realities with his or her community, and his or her spiritual reality (Truter 2007: 57). The hospital at which this study was carried out at, although a private health facility, catters for patients who would otherwise attend a government hospital for checkups and treatments. Most of the patients are from the black African background and

[5] Referring to biomedicine as it was 'inherited' from the Western system.

so too are the nurses. Thus, there is, relatively speaking, a shared cultural belief and understanding of health and illness shared by most of the nurses and the hospital patients.

1.3 Background and Rationale of the Present Study

According to Finkler (2004: 2048), the practice of biomedicine in many contemporary societies, (and this is true for the context of South Africa as well) has retained its original approach to health and illness. This so-called Western perspective to illness and health was itself perpetuated within the context of colonialism and 'globalisation'. However, many societies have their own cultural explanations of phenomena, including their perspective on illness and health (Vaughn, Jacquez, and Baker 2009: 65). Some illnesses, physical or mental, are peculiar and can only be understood within the cultural context in which they exist due to the cultural belief systems and practices of the people who believe and experience such illnesses (Vaughn *et al.* 2009: 66). As such, it is vital to understand how diagnosis is carried out in each society before any epidemiological view of the illness is presented (Finkler 2004: 2049).

Health and illness amongst the *isi*Zulu-speaking people, as one such example, is understood somewhat differently as it is in Western societies (see Bates 1997: 1447; Parle 2003; Quah 2003). In this study, I explored how the *ama*Zulu's perspective of culturally-understood illnesses, such as mental illness, *idliso* or convulsion, may affect and shape the approach of nurses to their patients and patient care. *Idliso* for example, as stated by Wilkinson *et al.* (1999: 840), "is reported to be 'man-made', and the illness is said to be causally traced to a person mixing traditional medicine ('*muti'*) with a 'victim's' food, in order to poison or bewitch him [sic]". Some of the symptoms such as dehydration, abdominal pain and headaches which present in some culturally-understood illnesses are similar to symptoms of biomedically recognized illness. For instance, in Wilkinson *et al.*'s (1999: 840) study on the collaboration between traditional healers and biomedical personnel, most of the traditional healers said they diagnosed had patients suffering from TB, but had thought that such patients were suffering from *idliso* due to the similarity in symptoms.

Our worldviews can be shaped by different catalysts such as societal, religious, political and cultural practices and beliefs. The focus in this study, however, is on cultural beliefs and practices as catalysts in worldview formation. According to an American anthropologist and social theorists Kluckhohn (1951a: 86), cultures are "the patterned ways of thinking, feeling and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievements of human groups, including their embodiments in artefacts… ideas and especially their attached values". The term culture has also been defined as the "transmitted and created content and patterns of values, ideas, and other symbolic –meaningful systems as factors in the shaping of human behaviours and the artefacts produced through behaviour" (Kroeber and Parsons 1958: 583). Whichever definition one may look at, culture is an embodiment of a people's cherished values which guide and shape their thinking and approach of the world.[6]

According to Hofstede (1980: 24), "culture is to a human collectivity what personality is to an individual" because "culture determines the identity of a human group the same way that personality determines the identity of an individual". Personality in this case will be the embodiment of certain conceptions about the world, implicit or explicit, that makes one choose a certain way of action over a variety of options. Hence, "human beings cannot divest themselves of culture; they are either participating in their own historical culture or that of some other group" (Asante 2003: 3). Nurses, and in this case, the *isi*Zulu-speaking nurses,[7] belong to a category of healthcare workers that are trained according to a so called Western system, but they also carry with them their culturally-embedded knowledge and beliefs about health and illness, otherwise known as 'Traditional Health Practice'.[8]

[6] Although the term culture may also refer to a variety of practices such as religious culture, political culture or economic culture, for this study, the term culture is used as the traditional practices of a group of people or so called 'ethnic group'.

[7] In this study, the term Zulu refers to the shared common culture of a people; *ama*Zulu refers the group of people who share the Zulu culture; and *isi*Zulu refers to the Zulu language or the language spoken by the *ama*Zlu. The terms *isi*Zulu-speaking people and *ama*Zulu will be used interchangeably to refer to the Zulu people. By *isi*Zulu-speaking nurses, I mean black African nurses of Zulu descent who have been raised within the Zulu tradition and have a good knowledge and intergenerational understanding of the Zulu cultural constructions and approaches to health and illness.

[8] As defined in the Traditional Health Practitioners Act, traditional health practice is "the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object the maintenance or restoration of physical or mental health or function; or the diagnosis, treatment or prevention of a physical or mental illness; or the rehabilitation

Some studies show how some patients in hospitals may still prefer the technologically advanced approach to medicine as stated by Kleinman & Benson (2006: 1674). Nonetheless, the effects of such treatments may necessitate a deeper understanding of culturally-embedded illnesses for a 'better' or at least more 'patient-relevant' care in hospitals. Such a necessity was presented in Naidu's (2012) study of cancer patients in a Durban hospital. Most of the patients in the study (Naidu 2012) were unhappy with the approaches used by some of the healthcare workers seem to ignore other aspects of their humanity and only focus on the sickness. Naidu (2012: 77) stated that "many of them (the cancer patients who were the participants in her study) mentioned that the doctors seemed to "treat the cancer ... not us (the patients) ..." (Naidu 2012: 77). Such patients would have been in touch with the reality that illness is not only about the disease or the ailing body parts, but about the person as a whole being. This view was supported by Gumede (2009: 54) in his Master's thesis when he said that "people have been educated about the basics to maintain good health, but these ideas sometimes rest on a deeper, more entrenched '*indigenous'* [my emphasis] understanding of well-being" thus leading to the suspicion some people have of biomedicine.

It has been suggested that the hegemonic hold of Western biomedicine began when much of the "Western cultural baggage" were being enforced on, or copied by non-Western societies (Macleod and Lewis 1988: 2). Writers (see Foucault 1975; King 1982) point out that biomedicine originated in the Nineteenth Century in Europe and thereafter diffused to other societies due to Western expansion and colonialism. Hence, the core aspects and view embedded within biomedicine have not undergone an anthropological microscopic analysis cross culturally; rather, they still "exist side by side with local medical regimes" (Finkler 2004: 2048). That is, they have not been able to find root in the societies in which they operate by incorporating the local understanding and approaches to health and illness, and rather, operate independently of such local views.

Approaching the complex issue of illness and health thus requires shared knowledge through an "active give-and-take communication" (Vaughn *et al.* 2009: 64). This give-and-take process will lead to the development of trust and confidence in any medical system that is in place in the society, if medical adherence, which is very vital to societal health practice, is to

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of a person to enable that person resume normal functioning within the family or community; or the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death" (Republic of South Africa 2004).

be achieved. The presence of boundaries between any health system and patients, in this case biomedicine and the traditional African medicine (TAM), can result in a set-back on the services provided by the system.

This study is consciously delimited. It does not, given the parameters of a Masters level study, look at issues of health care delivery as such. Instead, the study takes as a starting point that many of the *isi*Zulu-speaking nurses (although not all) who are trained in Western biomedicine and a biomedical approach to health, *may* encounter conflict within their own culturally-defined understandings of illness and health. As such, this study will probe the *possible conflict* in understanding and responding to issues of and aspects of particular illnesses, as faced by the *isi*Zulu-speaking nurses, and how they negotiate this conflict. The study is further premised on the view that by exploring the possibility of such conflict, we will become "increasingly vigilant of the dominant ideologies of illness and body, through which we are increasingly obliged to enact illness and health" (Naidu 2012:78) thus bypassing the possible impasse faced by nurses in patient care. Also, the study does not look at the general understanding of all *isi*Zulu-speaking nurses, not in the hospital and not in the country as a whole. It only looks at the understanding of the *isi*Zulu-speaking nurses in this study and when other cases are mentioned, it is only in comparison or for referencing purposes.

1.4 Significance of the Study against Other Studies

This research is considered vital, as there has not been, to my knowledge, studies specifically probing the effects of cultural conceptions of illness on *isi*Zulu-speaking nurses and how this is experienced by them. The few studies conducted do not present the possible conflict that cultural constructions may cause the nurses; neither do the studies show how the dual positions occupied by the nurses, as cultural and biomedical persons, shape and influence their approach to patient care and health care practice. For instance, there are studies such as Dahlberg and Trygger's (2009) study on indigenous medicine; and a study on primary healthcare in KwaZulu-Natal, conducted by Smith-Oka (2012). There are also studies on the analysis of indigenous reproductive health illness in Mexico, and Cocks and Møller's (2002) study titled, "Use of indigenous and indigenized medicine to enhance personal well-being: a

South African case study". These studies all look at similar cases as explored in this study, however, not from the same perspective this study took. They made reference to generalised traditional constructions of health and illness but did not probe how such constructions may cause difficulty for nurses and shape their attitude towards patient care.

Other studies such as Francis' (2007: 202) PhD thesis, in exploring the ethnicity and social change among *isi*Zulu-speaking Sans, made reference to the differentia that exists in approach to societal issues by the so called "traditional" societies as different from those of "modern" societies. However, there was little or no mention of the differentia in terms of medical dynamics of the traditional *isi*Zulu societies and how that shapes the worldviews of *isi*Zulu-speaking nurses or the *ama*Zulu in general. In his Master's thesis, Gumede (2009: 54) asserted that although "people have been educated about the basics of maintaining good health, but these are sometimes not always integrated with their indigenous understanding of well-being". He presented an exploration of how cultural approaches to illnesses are valued within the *ama*Zulu society; however, my study did not only limit my exploration to the understanding of illness amongst the *ama*Zulu. This study took a step further from other studies (see Francis 2007; Gumede 2009) to show how this cultural constructions of health and illness shape nurses' approach to illness and patient care in hospitals.

1.5 Research Problems: Key Questions that the Study Asks

1. To what extent do *isi*Zulu-speaking nurses feel attached to their cultural practices and beliefs regarding health and illness?
2. How does the *ama*Zulu's understanding of illness influence *isi*Zulu-speaking nurses' understanding of patient care?
3. How does the Western/biomedical approach to illnesses influence the *isi*Zulu-speaking nurses' understanding of patient care?
4. Do the *isi*Zulu-speaking nurses suggest alternative means of medication to patients that might be suffering from culturally-recognised and treatable illnesses, if so how do they do so?
5. To what extend do the nurses feel the Western biomedical approach supports patient care in or outside the hospital?

6. How do *isangoma* nurses view illness?
7. What are the healing rituals used by *isangoma* nurses in their healing and how do they shape their approach to patient care in the hospital

1.6 Research Problems: Broader Issues Investigated

This study looks at the broader issue of how biomedical approach to health care can be considered hegemonic within the South African health system and how such hegemony affects public health care. This hegemony was probed in how biomedicine gives little or no room to the local understandings and constructions attached to health and illness as adhered to by some of its nurses, especially at Bambanani Hospital. Thus, the study explored the need for a deeper understanding of culturally-understood illnesses and how such understandings shape *isi*Zulu-speaking nurses approach to patient care as a way of enhancing patient care in the hospital spaces.

CHAPTER TWO

Research Methodologies and Theoretical Frameworks

2.1 Introduction

Research, as defined by Kothari, is "a scientific and systematic search for pertinent information on a specific topic" (2004: 1). Gaining pertinent information about any given study or phenomenon is critical to any conclusion that will be made on any subject matter. However, accessing the needed data that will help in reaching a conclusion about the study cannot be reached without the presence of a methodological approach to the venture. As such, gaining a deeper understanding of the cultural constructions of illness amongst *isi*Zulu-speaking nurses and knowing how they understand and approach patient care, demands a methodological schema. The chapter looks at the methodologies and theoretical frameworks used in this study. Research methodology is defined by Kothari as a way of systematically solving a problem whereby various steps and methods are adopted in a research and reasons for using them are stated (2004: 8). To solve a problem "systematically", one needs tools, approaches, and methods. Research methods in this context, are the behaviours and instruments used in selecting, constructing and performing research. Thus, different methods were used hand in hand with theories to conduct, analyse, and to ascertain the outcome of the study. The necessity of theories for this research was considered based on the understanding that they serve as the guiding principles to any study, especially in anthropology (see Barnard 2000: 1; Creswell 2009: 51; McGee and Warms 2004: 1).

Exploring the research methodologies of this study enabled me to not only state the methods involved in this enquiry, but to also be able to take note of the logic for using each method and to state reasons for using them rather than other possible methods. This critical analysis of each method used gave and will give room for the results of the study to be read, analysed and understood by persons different from the researcher. Thus, in this chapter, I stated all the methods used for this study, their relevance to the study, and how they were used to reach the conclusions of the study.

2.2 Research Design and Methods of Data Collection

Research, as stated above, involves systematic investigations into a phenomenon, stating the plans which make up the design of the research is relevant. These plans can also be regarded as the justifications and meanings attached to each method and tool used in the research and manner in which the tools were used to achieve the outcome of the study.

2.2.1 Research site

The situatedness of a study plays a great role in the understanding of any given phenomenon, how the data related to that phenomenon is collected, and how the data impacts on the outcome of the study. This study took place at a non-profit based private hospital that operates and serves public health needs around Durban, in the Province of KwaZulu-Natal, South Africa. For ethical reasons, this hospital, from now on, will be referred to as Bambanani Hospital or the field. Bambanani Hospital was built in 1927, but initially established in 1882 by a group of Trappist monks.[9] Today, this District Hospital has the capacity of containing more than 500 admitted patients. Although still privately owned, Bambanani Hospital receives financial support from the South African government and other private international donors. It deals with patients who suffer from a wide variety of clinical conditions especially HIV/AIDS, pulmonary tuberculosis and diabetes and has also received patients with non-clinical illnesses from all localities but particularly the surrounding vicinity. Although this study is not about the hospital as an organisation, situating the study within the hospital was necessary as it gave room for a more in-depth participation and observation of the activities of the nurses and how they carry out their duties of patient care.

My choice of this hospital was based on many factors. Firstly, most of its patients were from the surrounding black neighbourhoods, most of whom were *isi*Zulu-speaking. As such, there were high chances that the nurses would have met with the reality of having patients with a belief in or suffering from illnesses that can be better understood and explained within the Zulu cultural context. Secondly, most of the nurses in this hospital were *isi*Zulu-speaking, making the chances of recruiting my research participants high. Thirdly, this was a hospital I worked in as a volunteer on two occasions during the school session breaks of 2011 and 2012.

[9] Trappist monks are a group of Catholic religious men who lived secluded and celibate lives but are now involved in missionary activities in different parts of the world.

Thus, I was familiar with the vicinity, many of its staff members, and the hospital authority. Due to this familiarity and my status as a former volunteer at the hospital, there was little or no difficulty in abtaining permission from the hospital authority to carry out the research. From my first day at the field, I was duly introduced to each department's matron by the Nursing Manager. The Matrons in each department in turn introduced me to the heads of staff and senior nursing staff in their units. With such warm welcome and great support that ran throughout my fieldwork from the first day, I was able to readapt quickly to the environment without much difficulty in creating rapport with the potential and later research participants. With the amount of ease I had within the hospital, I was able to work smoothly with the nurses and was constantly assisted with any answers whenever I had a question to ask.

The hospital is led by a board made up of nine members and led by a medical doctor as the hospital's Chief Executive Officer. The hospital is made up of five main units headed by Unit Managers also known as Matrons, and each unit has sub units headed by senor Sister or Sir Nurses who serve as Heads of Staff Nurses. The unit heads work during weekdays from 7:00 hours to 4:30 pm, while assistant matrons take over in the evenings and weekends. The five main units were the Medical Unit, Maternity Unit, Paediatric Unit, Surgical Unit, and the Out Patients' Unit. The number of staff attached to each unit and ward depends on the size of the unit, its responsibility and its workload.

2.2.2 Sampling and sample selection techniques

20 participants were recruited for this study.[10] I initially recruited my participants using purposive sampling as I had already identified and approached three nurses who had a deep understanding of health and illness from a Zulu cultural perspective and had met patients with such beliefs and illnesses. I later made use of snowball sampling, whereby the initially identified participants assisted in linking me to other potential participants who had had similar experiences and were willing to participate in the study. As I spent more time in the hospital, I also identified more potential participants and thereafter approached them and they agreed to be a part of the study.

[10] See Appendix 5 for the overview of research participants.

The 20 primary participants for the study were Sister (Sr.) and Sir Nurses[11] of mixed gender, different age groups and years of work experience at Bambanani Hospital. I chose to recruit 20 participants for this study because carrying out an ethnographic study demands more of qualitative data collection rather than just high numbers. Thus, this number was enough in providing me with the necessary rich data needed for the study considering it being a Master's thesis with a limited time frame. If not for the personally set limit on the number of participants, more participants would have been recruited as many other nurses became interested in participating in the study after enquiring about my presence in the hospital. However, the 20 initial participants remained my primary participants while other nurses who showed interest in the study became my secondary participants. From such nurses, I gathered my secondary data which helped me in correlating the data from the primary participants and from my observations. This group of secondary participants, however, were not included in the list of primary research participants.

I chose Sisters and Sir Nurses because their qualification and possible experience as trained nurses (as opposed to nursing attendants) determined the quality of the research. The assumption I had was that they would have been more knowledgeable in the practice of biomedicine and they would have had the most contact with patients and involved in more clinical decisions (as opposed to younger or less qualified nurses). Thus, they face more daily challenges, choices and clinical decisions in direct relation to each patient than the other health workers such as the nurse aids or nursing attendants (who do not administer medication as such). That being the case, the qualification and the nurses' level of contact with patients was my main criteria for choosing the *isi*Zulu-speaking nurses that were recruited from the hospital despite my awareness of the presence of other healthcare workers in the hospital.

Participants were from the age of 22 and above. This choice of age group allowed for cross-generational views on the issues looked at by the research, which is the influence of both Western and cultural approach to health and illness on nurses' understanding of illness and patient care. The gender of the nurses was not a criterion for selection. Nonetheless, despite the higher proportion of female to male nurses in the hospital and my readiness to

[11] Sister Nurses are female nurses who have undergone at least four years of formal nursing training in either nursing colleges or universities, while Sir Nurses are male nurses who have undergone the same training.

work with both genders, I made an effort to include both genders in the study. An attempt to create a balance in the gender of participants involved in the study would have been futile.

My reason for choosing only *isi*Zulu-speaking nurses rather than nurses from different so called 'ethnic' backgrounds was that there was a high possibility of similarities in views and understandings shared by only *isi*Zulu-speaking nurses in their cultural understanding of health and illness. This shared similarity was an important aspect for this study as the study was only focused on the understanding of illnesses within the Zulu culture. Although there were also divergent views amongst the *isi*Zulu-speaking nurses, which is also understandable.

2.2.3 Data collection

This study was a qualitative ethnographic research which took place from May to October 2014. Ethnography as an aspect of anthropology is regarded by Barnard (2000: 4) as "the practice of writing about peoples". As stated by Corbin and Strauss (2008:13) "qualitative research allows researchers to get at the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables". Participant observation used in anthropological ethnography can be defined as a form of research, which enables the researcher to live or spend time among the people he/she is studying (Smith and Fischer 1970: 34). This method of research combines two processes, which are "participation" and "observation". Pure observation as used in the sciences, "seeks, to the maximum extent possible, to remove the researcher from the actions and behaviours (he or she is observing) so that they are unable to influence him or her" (DeWalt and DeWalt 2002: 19). On the other hand, pure participation, which has been termed as "going native" (see Jorgenson 1989: 15), is "when a researcher sheds the identity of investigator and adopts the identity of a full participant in the culture" (DeWalt and DeWalt 2002: 19). The concurrent use of both participation and observation, however, were considered suitable for this study. Using one or the other in isolation or to its extreme would have either weakened my analytical content or would have led to the loss in rich ethnographic data. Besides, I could not have been a pure participant in the hospital situation because was not a trained or qualified nurse. While participation can lead to emotional involvement in a study, observations require detachment, and both are needed for a good research. Corbin and Strauss (2008: 29) alluded to the fact that it is not foreign to hear a person say they are doing one thing for one reason or the other while in reality they are carrying out different actions from

what they say they do. As such, the experiences I gained while participating in some daily activities of the participants also became a rich source of my data as it enabled me to correlate what the participants say and what I observe.

This method of anthropological research replaced the pre-Malinowskian mode of anthropological research, which was either armchair anthropology or by the use of informants. I also spent some time with some of the nurses outside the hospital area, especially visiting their homes, for those who were comfortable enough to let me. Doing this helped me to be a part of both their profession and non-professional lives as the environment they were could have influenced their ease, comfort ability and openness to me and the study. More so, some participants were comfortable to speak about their activities both within and outside the hospital area. I informed them that I was there as an academic researcher, not to judge or criticise but to only note and try to understand their stories and experiences.

One of the ways in which I gathered my data was through semi-structured interviews. A semi-structured interview is a method of interview that is designed using a number of interview questions prepared in advance (Polkinghorne 2005: 5). These questions, however, are open-ended and flexible, thereby differentiating this approach from a structured interview. This approach enabled me to be flexible to the order in which the questions and topics were discussed and more importantly, to allow the interviewee build up ideas to be discussed in a wider scope. Thus, the answers were also open-ended. I was regular within the hospital vicinity and had access to the participants; thus, each participant was involved in at least two formal interviews with other follow up interviews. Each interview lasted for about 45 minutes, but each participant had a choice of making it longer or shorter depending on his or her disposal to either discuss further or not.

The locations for the interviews were mostly within the hospital area except for participants such as Sr. Nelisiwe, Sr. Thabile, Sr. Mpume, Sir Thabiso and Sr. Andiswa whose homes I was able to visit during the ethnography. The reception I received, which ran through the hospital's ranks, greatly shaped how much of the nurses availed themselves whenever I had any question related to my research or wanted to interview them. They were confident in assisting me because my presence and purpose at the hospital had been noted and approved by the hospital's authority; hence, they had nothing to fear about participating in the study. As such, some interviews were held at the hospital area while others were held at the

participant's homes, depending on which location each participant found most convenient. Being flexible with the location and time of interviews was based on the assertion that "a sensitive interviewer knows when to step aside and let the interviewee guide them" (Corbin and Strauss 2008: 28). This guidance, in this research, was not only given to the participants during the interviews, but even prior to the interviews.

The use of multiple data gathering methods, which are the use of ethnographic data from interviews, observations and literature, helped me to make use of triangulation for the data analysis. As argued by Seale (1999: 465), the reliability of qualitative research can be questionable given that there are no statistical checks in the case in quantitative research. However, following the triangulation strategy used in validating ethnographic data, I was able to overcome this possible loop hole. This method allowed me to analyse the collected data from participants with the data collected from other similar studies, literary discussions around the issues dealt with in this study and my observations (Mathison 1988: 13).[12]

Information gleaned from participant observation and discussions with the nurses during work times were also included in the data. For interviews, I made use of an audio recorder. The permission for its usage was included in the participant consent and information form and I also confirmed its usage with each participant before the commencement of any formal interview with them.

2.2.4 Data processing and analysis

As asserted by Corbin and Strauss (2008: 46) "a researcher cannot continue to collect data forever. Sooner or later 'something' has to be done with that data to give it significance". That "something" was my analysis of the collected data. Corbin and Strauss went on to state that "analysis is a process of examining something in order to find out what it is and how it works" (2008: 46). Thus, after my data collection, I began the process of my data analysis in order to find meaning from the collected data. I transcribed all electronic recordings and afterwards coded my interviews and the identities of the participants to make my data analysis

[12] Focus group is another research method that could have also been used in the data collection and crosscheck of participants' views; however, it could not be used in this study. As stated by Denscombe (2010: 179) the comparison of data that can arise through the use of focus group helps to create an understanding of the different responses around the research topic. Nonetheless, with the involvement of senior staff members of the hospital in the study, who do not share the same break times and participants expressing fear of other participants hearing their personal views, having such group meetings was not possible. Despite leaving out this method, the quality of data collected was not in any way affected.

workable. The collected data was analysed manually as the coded information was in my field notes and transcribed data. I separated the data into themes, which emerged during the course of the ethnography and data collecting process. Each theme had sub-topics, based on the general points discussed by participants. I particularly made use of microanalysis. According to Corbin and Strauss (2008: 58-59), microanalysis is a detailed form of open coding which allows the researcher to "break open the data to consider all possible meanings". This form of analysis enabled me to build sub-themes from the main themes that I discovered from the data and gave room for new possible themes which contributed to the 'build-up' of chapters.

Reflexivity and personal interpretations are imperative aspects of a research. This is so because one cannot totally take away his/her personal feelings and experiences from how he/she interprets what he/she observes or hears (Rosaldo 2003: 583). As such, my analysis of the collected data and observed reality of the nurses took the vantage point from which I view and understand society and the studied phenomenon. However, taking a conscious note of the possible effects of dwelling too much on my personal interpretation, I tried to minimise, where possible, any personal views and accepted; rather, the meanings attached to any phenomenon by the research participants.

2.3 Ethical Considerations

I submitted my proposal to the University of KwaZulu-Natal's Research Office for ethical scrutiny and the study was granted a full approval.[13] This was done in order to ensure and safeguard the human rights of the participants and uphold the ethics of researcher and study in accordance to the university's ethical code of research conduct.

Informed Consent and Voluntary Participation

I sought permission to carry out my fieldwork from the hospital authority and I was given consent before I embarked on my fieldwork.[14] In recruiting participants, I gave them the full information about my study and its intention. After informing the potential participants about the study, they role they stood to play and were willing to be a part of the study, I provided

[13] See Appendix 1 for UKZN's Ethical Clearance Letter.

[14] See Appendix 2 for Gatekeeper's Consent Letter.

them with the research information form to go through. After they showed an understanding of what the study was about and the role they stood to play in the study, I signed the informed consent forms as they also did the same with both of us keeping a copy for referral purposes. This process was done with each participant individually and privately.

The informed consent and information letters were both in English and *isi*Zulu.[15] Participants were nurses who had been trained for at least four years in biomedicine using English. Aside from that, during my volunteering period at the hospital, I noticed that there were also non-*isi*Zulu-speaking staff and patients. Thus, the nurses are legible readers and speakers of the English language as they communicated with non-*isi*Zulu speakers in English; hence, there was no need for an interpreter. Nonetheless, writing the information form, informed consent form and the interview questions in both *isi*Zulu and English was to cover cases whereby a person might have preferred either language. No participant, however, opted to be interviewed in *isi*Zulu, nor did they feel I needed to write the forms or questions in *isi*Zulu. Rather, they commended such a gesture despite it not being needed by them. In cases where a person would have chosen to be interviewed in *isi*Zulu, I would have sought their permission to use an interpreter as I was not fluent in *isi*Zulu. I would have made use of such an option despite the possible loss of some information through the use of an interpreter. Such an avenue of choice; however would have allowed for participants' own preference to be privileged, which is vital for any study.

I informed each participant that participation in the study was voluntary and that they could withdraw from participating at any time without incurring any penalty for withdrawing. In addition to that, I made each participant aware that there were no incentives or financial benefits for participating.

[15] See Appendix 3.1 for the English version of the Information form and Appendix 3.2 for the *isi*Zulu version. See Appendix 4.1 of the Ethics form for the English version of the Informed Consent Form and Appendix 3.2 for the *isi*Zulu version.

Confidentiality

As asserted by Lofland, Snow, Anderson and Lofland (2006: 15):

> One of the central obligations that field researchers have with respect to those they study is the guarantee of anonymity via the 'assurance of confidentiality' – the promise that the real names of persons, places, and so forth will not be used in the research report or will be substituted by pseudonyms.

It is in this light that I assured participants of the protection of their identity in the write up of my thesis or in a situation whereby the obtained information will be published or discussed verbally. I kept all collected data safe and confidential in protected files and electronic devices where passwords were applied. After notifying them of all the conditions involved in the study and the role they stood to play, each participant and I signed the agreed consent forms, which each participant kept a copy while I kept one from each participant.

Although I assisted the nurses in carrying out some their duties such as feeding or cleaning the patients, at no point did the study involve interviewing the hospital patients as this was of course not the scope of the study and would have impinged on the patients' rights.

2.4 Study Limitations

In this study, there were a few challenges encountered that led to the limitation of the study. Although I had no problem gaining access to the research site and participants, the target of being able to physically be at the research site 6 times a week for the period of at least 5 months was not achieved. This shortcoming was due to financial constraints as there were no available funds throughout the course of the study. Thus, I was only able to gather as much data as I could within the period and times I was able to visit the research site.

Also, due to financial constraints, I was unable to visit the homes of most of the nurses despite their expression of great willingness to be visited. This challenge limited the amount of data I would have gathered through my observation and interaction with the nurses outside

the hospital space. Gathering more of such data would have helped me to assess their health-related behaviours outside the hospital with those within the hospital.

Another challenge encountered in the course of the study was the barrier caused by language. Although all participants were comfortable communicating in English, there were times when phrases or words were said in *isi*Zulu and would have been best understood if I understood the *isi*Zulu language in-depth. At such times, I had to depend on the interpretation of such words or phrases by the nurses. They also expressed difficulty in directly translating such words or phrases into English. They said they are either unable to find the right translation or the meaning of the words or phrases would be lost in any attempt to translate the word or phrase.

2.5 Principal Theories, Models and Frameworks

Anthropology as defined by McGee and Warms (2004: 1) is a study "concerned with understanding the 'other'. …anthropologists study the behaviour, beliefs, and lifestyles of people in other cultures". Contemporary anthropologists, however, are able to carry out emic studies and still produce unbiased findings. Whichever approach taken, there is need for some guiding principles when carrying out any study in either one's society or that of others. These principles serve as conceptual and theoretical frameworks in enabling anthropologists carry out their research and give meaning to their data (McGee and Warms 2004: 1). As such, theories are core tools in all fields of study and disciplines, especially in anthropology where theory is closely bound to practice (Barnard 2000: 1). Creswell (2009: 51) defines a theory as "an interrelated set of constructs (or variables), formed into propositions, or hypotheses, that specify the relationship among variables (typically in terms of magnitude or direction)". Thus, for this study, I employed the use of Identity theory, Social Constructivism, The Health Belief Model, and Structural Violence Theory. While the first three theories were envisaged from the onset of the study, structural violence theory emerged after the course of my fieldwork as much of the data suggested a strong link between the narratives shared by the participants and the views in the theory.

2.5.1 Social Constructivism

Social Constructivism, sometimes referred to as Social Constructionist Theory, is a theory which claims that "knowledge (human) is acquired through a process of active construction" (Fox 2001: 23). It is a symbolic equation that depicts learning and acquiring knowledge as a process of building. The theory argues that we are not born with innate knowledge; rather, we acquire and build our knowledge, views and behavioural approach to our society and its realities (Fox 2001: 23). This is so because we are indissolubly interconnected with the environment we live in and its belief system, as asserted by Ernest (1994: 8).

The use of Social Constructivism in this study aided me to understand how the *ama*Zulu's society and culture has shaped the *isi*Zulu-speaking nurses' idea of health and illness. It also made me hold in high regards the views of the participants in this research for the thematic formation of the research. Social Constructivism was also useful in this study as it enabled me to understand how the behavioural patterns of *isi*Zulu-speaking nurses towards health, illness and patient care have been shaped by their society and its cultural constructions. It also allowed me to give room to the views of the nurses in understanding how they view the world and its systems. This is because, as asserted by Creswell and Garrett (2008: 8), the participants' views "are not simply imprinted on individual but are formed through interaction with others and through historical and cultural norms that operate in individual's lives". Thus, Social Constructivism served as a lens from which I viewed and understood the cultural beliefs about health and illness as understood by this group of *isi*Zulu-speaking nurses.

2.5.2 Social Identity Theory

Another theory used in this research was the Social Identity Theory, otherwise known as Identity Theory. This theory is defined by Jenkins (1996: 90) as "the constitution in social practice of the intermingling, and inseparable, themes of human similarity and difference". Such similarities and differences can only be conceived within a group thereby shaping the members' identity. There are situations whereby one can choose his/her social group, which will in turn determine his/her identity. In such situations, identity can be seen as "the totality of one's perception of self, or how we as individuals view ourselves as unique from others" (Bhugra and Becker 2005: 21). In other situations; however, one becomes part of a group such as an ethnic group, a family, or a clan through a natural process without making any personal choice or effort. In understanding who we are, who other people are, and how other

people view themselves, identity can then be termed as the construction of an internal-external dialectic between self-image and public image (Jenkins 1996: 25).

The use of Identity Theory in this study helped me to understand how the identity of nurses as bio-medically trained personnel and culturally situated people "determine" the role they play and how they play such role or roles in patient care. It also helped me to assess how the nurses' cultural beliefs and practices influence and shape their professional identity and practice as biomedical personnel who are expected to work within specific ethical codes. Understanding the possible conflict of identities amongst the nurses led me to gain a better knowledge of how such a conflict of role or identity affects and influences their approach to patient care. This theory also showed how the nurses are able to change, negotiate, and fluidly renegotiate their identities when faced with any clinical decision in or outside the hospital space.

2.5.3 Health Belief Model

Our behaviours and beliefs, which have been constructed due to our interaction with our society, play a role in how we approach health. Thus, I also made use of the Health Belief Model (HBM) for this study. The HBM is a systematic explanation and prediction of preventive health behaviour that was developed around 1952 by Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock. This theory seeks to understand people's health behaviours and their general health motivation in order to "distinguish illness and sick-role behaviours from health behaviour" (Hochbaum, Rosenstock and Kegals 1952: 1).

This model was useful in this study as it focuses particularly on health approach/es. Thus, it enabled me to create a more critical and in-depth analysis of the societal constructions of health and illness shared by the research participants. The analyses portrayed how their societal constructions of health and illnesses have shaped their health belief. HBM seeks to predict and understand how people's health-related behaviour is shaped by their belief patterns (Hochbaum *et al.* 1952: 2). This theory can be situated within the Zulu culture and its belief on health and illness. It particularly shows how the *ama*Zulu's culture and its belief on health and illness shape nurses' understanding of illness and patient care. This study does not only explore the cultural understanding of health amongst nurses, but does so in relation to how their understandings affect patient care. Hence, understanding the health belief model of

the nurses also helps us understand what belief systems shape public health care in the hospital.

2.5.4 Structural Violence Theory

Structural violence is a concept introduced in the 1960s by Johan Galtung, a Norwegian sociologist and mathematician who is renowned as a founder of the Discipline of Peace and Conflict Studies. Structural Violence discusses how "social structures – economic, political, legal, religious, cultural, [and medical] (my addition) – stop individuals, groups, and societies from reaching their full potential" (Galtung 1969: 168). Although the word 'violence' may connote a physical image and impact, Galtung (1993: 106) however, states that the word is the "avoidable impairment of fundamental human needs or… the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible". The narratives shared by the participants suggested a strong impairment on the totality of their being, which includes their cultural selves with the beliefs and practices that comes with it. Such impairment is what is contained in the Structural Violence Theory. As stated by Gilligan (1997: 306), "Structural Violence is often embedded in longstanding ubiquitous social structures, normalized by stable institutions and regular experience". These structures are usually supported by one culture or the other, thus, cultures end up justifying the violence practiced within the societal structures

This theory is relevant to this study as it was able to show how the hospital space becomes an institution which harbours the violence conceived by biomedicine as a practice towards persons, beliefs, and practices that are foreign to it. Biomedicine, as sometimes referred to as "Western" medicine, is a practice that carries with it the Western culture and beliefs towards health and illness. The oppression of one culture over another can be regarded as social injustice. As Farmer (2004: 306) had inferred, the notion of structural violence has a strong connection to social injustice. Based on Galtung's (1993: 106) view of the violence enacted on people, the situation faced by the nurses can be said to be an "avoidable impairment", yet, it "lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible". Thus, the use of this theory helps us to understand how structures and power have shaped individuals' lives and only then can we begin to work towards a change of such influence of the fixed structures and systems. In order to amend this impact, we need to begin to "study the state and other political institutions not, as we typically

do, from the top down, but rather from the bottom up" (Bevir 1999: 353). In doing this, the techniques used by different disciplines and institutions need to be examined in order to fix how people construct and conduct themselves in relation to others.

2.6 Structure of the Dissertation

CHAPTER ONE: Introduction and Literature Review

The introductory chapter of this study looks at an overview of public health in South Africa as a backdrop to the study. It goes on to explore the existing research on the field of biomedicine and its relatedness to culture and cultural understandings of illnesses. This helped in discovering the existing gap in the available literature on the subject matter discussed in this study. Explaining the rationale of a study helps in showing how valuable the study could be to the field it is carried in. Thus, I also explored this aspect in the first chapter by showing the significance of the study and the key questions that guided and shaped the study. These key questions were both the particular questions addressing the issues of this study and the questions bordering the broader issues that were investigated in the study.

CHAPTER TWO: Research Methodologies and Theoretical Frameworks

In this chapter, the methodologies and theoretical frameworks that were used in the research were presented. I gave the reasoning behind the use of each methodology and its contribution to the data collection and analysis of the study. In doing this, I discussed the site in which the study was carried out, how the research participants were recruited, how the data was collected and the tools used for such. Aside from situating the study, constructing and expatiating the methods of data collection, sampling and sample selection techniques, and data processing and analysis needed to be clearly stated. In addition, because this study involved people, there was a need to clearly state how I handled the ethical issues regarding this research. As such, I stated the possible ethical issues that would have arisen in this study and the actions I took to avoid them. I then presented the principal theories, models and frameworks upon which the research was based and afterwards presented the structure of the dissertation.

CHAPTER THREE: Nurses' Understanding of Illnesses and Healing

This chapter looks at how the societies and cultural understanding of realities of the *isi*Zulu-speaking people affect, influence and shaped the health beliefs and approach to illness of the *isi*Zulu-speaking nurses in this study. It explored the meanings and understandings the *isi*Zulu-nurses attach to illness and healing and how that has been shaped by the *isi*Zulu cultural beliefs on illness and healing. The chapter covers some of the cultural belief systems and practices as practiced by the *isi*Zulu-speaking people. Practices and beliefs, such as the role of the environment, ancestors and bewitchment of people, are adhered to by the *isi*Zulu-speaking nurses in this study. Thus, this adherence shapes their understandings of illness and healing.

CHAPTER FOUR: Being a Nurse and a *iSangoma*

In the course of my fieldwork, I discovered that some of the *isi*Zulu-speaking nurses in the study were also *izangoma*. This chapter covers the conception of illness from the perspective of the *isangoma* nurses, the process that takes place when consulted by a person, and the type of healing medications and rites they recommend to people.

CHAPTER FIVE: Nurses' Understanding of Illness Shaping Patient Care and Illness

We view the world from a certain perspective, and our perspective of the world and phenomena has been shaped and influenced by our society, its beliefs and practices. The Zulu culture, with its practice and beliefs, also influences *isi*Zulu-speaking nurses. Thus, this chapter explored how the cultural understanding of illnesses adhered to by the *isi*Zulu-speaking nurses in this study shape and influence their clinical decisions.

CHAPTER SIX: Summary

This chapter takes an overview of the whole study by explicating some of the research findings and how they impact on the entire study. I then presented my conclusive view towards them and the possible recommendations that could be adopted from the study based on their possible contribution to the understanding of health and patient care in Bambanani Hospital.

CHAPTER THREE

What is Nurses' Understanding of Illnesses and Healing?

3.1 Introduction

By living within societies as humans, we develop certain prevailing points of view including how we understand health and illness. Our prevailing points of view, also known as 'worldviews' or positioning, are a result of the dialogue between us and our society (Creswell 2009:8). This view is strongly held by social constructivists in their assertion that "knowledge (human) is acquired through a process of active construction" (Fox 2001: 23). As such, we approach reality from our particular point of view which has been constructed and developed over time (Rosaldo 2003: 583).

Different societies have their practices and beliefs, as well as their approach to health and illness (Naidu 2013: 257; Naidu 2014: 147; Vaughn *et al.* 2009: 65). Such practices and beliefs affect members of such societies and contribute to building their worldviews. As Whyte, van der Geest and Hordon (2002: 118) assert, many factors "influence people's response to ill-health, including entrenched beliefs". As such, the understanding and approach to illnesses vary from one society to another, one setting to another, and one belief system to another. This chapter looks at what *isi*Zulu-speaking nurses understand by illness and healing. It explores what sickness means to the nurses. In exploring this understanding of nurses, the chapter explored the cultural belief system of the Zulu culture and some of its practices, which in turn shape the nurses' understanding of illness.

3.2 Nurses' Understanding of What It Means To Be Sick

> *…to be sick means that there is a certain part of a person's body that is feeling unwell. One will be experiencing some sort of illness and is able to tell the next person what is wrong with them (Sr. Nothando).*

These were the words of one of the research participants, while I assisted her in taking a patient's blood pressure, Sr. Nothando, an energetic senior nurse in the maternity ward. During my time with the nurses, they shared various understandings of what they felt being sick meant and how each illness could be interpreted based on its cause. The idea and linkage of illness to the body came out strongly. In one of my conversations with Sr. Nothando, she said: *"what we do here has to do with what is wrong with the patients' body*".

Sr. Nothando was not the only participant with an understanding of illness based on the state of one's physical body. Sr. Phindile also shared a similar conception of illness while we were on tea break with other nurses in the ward, one of whom was a participant in this study. Although she was very busy handing over her post to another senior nurse, Sr. Phindile made time to help out in the research by meeting during her tea breaks. She said we should not "mix up" what it means to be sick with our "old traditional beliefs" but understand from what we have been taught (referring to the nursing training). She continued:

> *…it means the person's body or system is not functioning in the normal way that it is supposed to be functioning and it could be caused by anything. This can be due to certain circumstances, maybe the weather, maybe allergy. You know when the pollens are opening up before summer; some people are allergic to pollen. So when you inhale the pollen, your system stops to function normally because you are allergic to those. Even in windy conditions somebody will inhale dust, your body will not function well. Maybe it was due to a reaction. Maybe there was a bee sting or whatever; but it will make your system not work properly….*

Here Sr. Phindile and Sr. Nothando did not only state the strong connection they had of illness to the body, but also stated how the body gets to this "ill" state. Their view of the body as a "system" portrays it in a rather mechanical manner whereby each part can be separated from the person. Viewing the body in this manner works towards the dissection of the human person into various body part. This approach shows how some of the nurses have adopted the dissected view of the human person as practiced in biomedicine. As asserted by Capra (1982: 346), biomedical specialists are keener on body parts rather than the whole person, thus prompting the promotion of biomedical personnel to become specialists in certain body parts.

Sr. Nontokozo also had a similar conception and the link of illnesses to the body. This friendly nurse sometimes gave me a lift from the hospital to the taxis. We were once on our way out of the hospital when a conversation ensued about an elderly woman who had been brought in by the paramedics.

> *Illnesses are partly natural because we are in the human body, and if there is something wrong with that body, one will get ill. So it can just be the body deciding to go, otherwise from its natural state due to maybe old age just like that granny (referring to the patient we had seen being taken into the ward) and there is nothing we can do about it hey (Sr. Nontokozo).*

Similar to Sr. Phindile and Sr. Nothando, Sr. Nontokozo showed that illnesses are situated within the human body, and in this case, caused by advancement in age. She was of the opinion that although the woman might have been suffering from several illnesses, the age of the woman played a role in her proneness to such illnesses. This, she said, was because at the woman's age, her body and immune system was too weak to fight against some minor illnesses as the body of a younger person would. Such an understanding of illness as a phenomenon of the body is not foreign within the biomedical field. As Parle (2003: 108) stated, such an understanding has been "inherited through Western biomedical models of approaching illness", an approach in which the nurses have been trained. Biomedicine, says Capra (1982: 348), does not make "practical attempts to deal with psychological and social aspects of illness therapeutically" but deals mainly with just the physical body. Twigg (2002: 426), for example, stated that in the modern world, especially in biomedicine, "the body becomes an object for scientific enquiry, to be studied in terms of scientific causality".

However, as Naidu (2012: 78) had expressed, it is through the body that "we are increasingly obliged to enact illness and health", and there is need for an increased caution "of the dominant ideologies of illness and body" as illnesses impact on people as whole beings.

The state of ill health, however, can be caused by a variety of phenomena or factors. Passing through the OPD to the X-Ray Department of the hospital, conversation ensued between Sr. Nosipho and me. We started chatting about the possible causes of the illnesses suffered by the patients with this senior Sister Nurse who is also undergoing an advanced midwifery programme at the University of KwaZulu-Natal (UKZN). We 'bonded' as we shared a common identity, that of being UKZN students. Although when Sr. Nosipho was younger, she hoped to become a police woman when she grew up, her mother decided that she studied nursing. She said "*I see it as a way of God directing me somewhere. Because now if I ask myself why I wanted to become a police, I am not able to find any reason. But being here, I feel fulfilled as it is where I belong. I am very satisfied, especially when I help someone who is in need then I know that it was God who directed me to this side".* During the conversation, she reminded me of an earlier conversation we had about the possible cause of an illness that was undetectable by the doctors.

> *Gabe (a name most of the nurses began calling me as I spent more time with them), you see, as many of these patients are here (spreading her arm towards the patients waiting in the OPD's corridor), so too are their illnesses. And even those who might have the same or similar illness, each person's might have been caused by something different from the other- yet they all end up with certain diseases or some emotional imbalance. But I have heard and seen situations whereby a person is ill but the cause was not able to be detected.*

The cause of an illness strongly determines how it is explained and defined. Many writers have put forward different definitions of what sickness is (see Aronsson, Gustafsson and Dalner 2000: 502; Finney 1963: 206; Goldstein 1958: 773). One of such definitions was asserted by Hahn, an American epidemiologist and anthropologist. He asserted that sickness means "unwanted conditions of self or substantial threats of unwanted conditions of self" (1995: 22). Arguably, by referring to sickness as "unwanted conditions of 'self'", Hahn shows an understanding of a person as a whole, physical, psychological and spiritual. This

understanding is more encompassing as opposed to the "traditional" Western view that tends to delineate other aspects of the human person and only gives regards to the physical body when understanding ill-health. Sickness is an umbrella term for both disease and illness. Disease is regarded as "the outward, clinical manifestations of altered physical function or infection" (Brown *et al.* 2005: 11). This definition is entrenched in the belief that a person's health is a "clinical phenomena, defined by the pathophysiology of certain tissues within the human organism" (Brown *et al.* 2005: 11). Most approaches to a person's state of well-being within the biomedical sphere are shaped by this definition of disease.

Illness, however, "encompasses the human experience and perceptions of alterations in health as informed by their broader social and cultural meanings" (Brown *et al.* 2005: 12). Thus, amongst the *Nguni,*[16] ill health is regarded as an "intrapsychic, interpersonal or social disharmony" with either one's environment or others, including the ancestors (Edwards 1985).

The various explanations of ill health, its causes and how it is viewed by the research participants such as Sr. Nosipho, Sr. Nontokozo, and Sr. Phindile, led me to probe deeper into what such factors could be. As some writers (see Bates 1997: 1447; Parle 2003; Quah 2003) have stated, health and illness is understood amongst the *ama*Zulu somewhat differently as conceived in Western societies. Sir Siyanda, a very assertive senior nurse in the female medical ward, once said to me: "*whatever one may say about illness, it is a personal feeling which can make a person weak, lose weight, appetite and energy, but the person usually is likely to know what got them ill, and only they can say what it is".* Thus, understanding some of the ways a person can get ill and if the *isi*Zulu-speaking nurses shared similar views about the ways of getting ill became crucial to the study.

[16] Nguni is a name used in collectively referring to "a major group of Bantu-speaking peoples belonging to the Negroid racial group of Africa living in the summer rainfall areas between the Drakensberg and the Indian Ocean and along a brad belt from Swaziland through Natal southwards into the Transkei and Ciskei. The Northern Nguni comprise of the Swazi, Zulu, and Ndebele peoples of the high veld; and the Southern Nguni include the Xhosa, Thembu, Bomvana, Mpondo and Mpondomise" (South African History Online 2014). Although these groups may have similarities in some of their cultural practices, a practice such as circumssision, however, may be practiced in some of the groups such as the Xhosa group but not amongst the *amaZulu.* This practice was abolished by Shaka Zulu before the unification of different people who later became known as the *amaZulu*. As stated by Nkosi (2008: 150), "Zulus [sic] abandoned the ritual initiation rites of male circumcision during the Shaka period of history but some circumcise by choice, undergoing medical or traditional circumcision".

3.2.1 *"Our environment can also be dangerous, you know"*

> *This (ill heath) can be due to certain circumstances, maybe the weather, maybe allergy of food or other things. You know when the pollen is opening up before summer; some people become allergic to the pollen grains. So when you inhale the pollen, your system stops to function normally because you are allergic to those. Even in windy conditions somebody will inhale dust, your body will not function well. Maybe it was due to a reaction. Maybe there was a bee sting or even maybe say a plant or whatever; your system will not work properly, and this shows that our environment can also be dangerous, you know (Sr. Phindile).*

These were Sr. Phindile's words as I sat with her in her office assisting her in arranging some pile of documents. She cited an example of how she had seen the possibility of the natural environment impacting on one's health.

> *Something happened around my community. People ate something that they thought were good mushrooms. They ate the mushrooms that are grown in the field that are not meant to be eaten, they ate them and they fell terribly sick. They should have known that those are not meant to be eaten but they still went on and ate them. I am not sure whether some people died or whatever, but one can die from those.*

Another participant, Sir Jabulani also shared a similar view of the possible "dangerous" impact the environment can make on our health. Sir Jabulani was a tall dark-complexioned senior nurse who worked in the OPD. He was one of the friendliest nurses I met at the hospital and he was always willing to explain anything he was doing with the patients, from blood transfusions to administration of medication. This 31 year old nurse said:

> *There are so many things that can cause this ill health. It can be the environment, it can be what a person eats, it can also be the type of job a person does, it can also be where a person stays, if it is not conducive enough. It can also be allergies that a person is having.*

I listened carefully to this well-spoken nurse who does not only have a degree in nursing, but also showed deep general knowledge. Dubos (1987: 1-2), stated that the "very process of living is a continual interplay between the individual and his [sic] environment, often taking the form of a struggle resulting in injury or disease". It has also been noted by Kirsten *et al.* (2009: 4) that if a person's environment ceases to be healthy, his or her wellness will also suffer an adverse effect of the environment's state of being. This relationship of a person's health with his/her environment is a belief that is at the heart of both eco-systemic anthropology and traditional medicine. It is a belief which asserts that for a person to be well there needs to be a healthy environment in which he or she lives in.

3.2.2 *"…he was bewitched because he was clever at school"*

I visited the hospital six days each week throughout the ethnographic period, and that gave me the chance to listen to the nurses' stories on how patients claim to be bewitched or how they have had personal experiences of bewitchment. Some of them also shared stories of how they or their children were bewitched at one point or the other in their lives. Sr. Andiswa for instance, narrated an incident where a child's illness was regarded as bewitchment by the child's family as a first form of reaction. Sr. Andiswa was generous with her time when possible. She seemed passionate about her job as she said she has always wanted right from her childhood. She said: *I was in grade 10 when my grandmother was sick; I was the one taking care of her and my passion developed from then. I generally like helping people especially sick people and I realised that I am good with children. I love seeing children growing, and advising and taking care of the babies.*

While playing with the children with her, she told me about many incidents she had seen where bewitchment was claimed to be the cause of the person's illness. One of such was the case of a 12 years old child admitted in her ward.

> *There was a 12 year old child who was admitted here with TB and meningitis. He was admitted post operation because the mother told us that the child complained of headache and the following day he did the same. They gave him Panadol and he went to school, but on the third day on his way from school, the child fell and collapsed. The first thing they said it was bewitchment.*

Sr. Andiswa went on explaining to me how the family took the child to an *inyanga* and yet the child's condition did not improve; hence, they were almost forced to bring the child back to the hospital. However, by the time the child was brought back, he was unconscious and they had to refer the family to another hospital for more treatment and it was discovered that the child had TB and meningitis. He was resuscitated and treated in that hospital but brought back to the hospital for proper recovery. Despite an effort to explain to the parents what is wrong with the child, the parents seemed not to understand.

> *Even though the explanation was given that this child had meningitis, the family still believed that it was not meningitis. That he was bewitched because he was clever at school, the family was doing well and so they believed that someone was against them. I understand why they kept thinking so because I know that these things (bewitchment) happen because some people can have great powers to do so. We have some connection to each other and we are supposed to keep up with the common spirit of living connected as it has always been from old generations, but unfortunately some people use it wrongly (Sr. Andiswa).*

The connection people share may be through a natural bonding, as in family relatives, but also by sharing the same communal space or beliefs. Most of the participants expressed a deep belief in an interconnection with people within one's family and community. Living together, however, there is always a possibility of misunderstandings and tension amongst people. While some may take to the formal dispute resolution process of reporting an offender to the community head or the civil authority, others may resort to the use of "traditional" medicine (*muti*) in order to poison or "bewitch" a person they dislike or has wronged them.

The African view of a person as a communal being linked to other beings through some "vital force" in the cosmos still plays a huge role in the development of contemporary *ama*Zulu's worldviews. This concept means that a person exists within the community, but his or her life can be greatly influenced by the "vital force" and shared spirituality of other beings (Nussbaum 2003:107). Sr. Xoliswa alluded to this possibility of people using the connection they have with others and the power in them to harm others as opposed to the expected norm of mutual harmony. Sayings such as *umuntu ngumuntu ngabantu* – it is through others that one attains selfhood (Edwards, Makunga, Thwala, and Mbele 2009: 1) stem from such views

and expectations of communal harmony. Thus the Shonas of Zimbabwe will say "*ndarara, rana mararawo* – I slept well, if you slept well, and *taswera kana maswerawo* – my day has been good, if your day has been good" (Asante 2006: 154).

Also narrating another incident of a patient who was said to have been poisoned, Sr. Xoliswa narrated how she was once faced with a patient whom she thought had TB but did not respond to the appropriate treatment of TB.

> *I failed to understand why the child was not responding to the treatement even though he shows all the symptoms of TB. Then the aunt said she believes that the problem was caused by idliso (food poisoning) because the in-laws were against her. That they wanted to kill her, so they had put some idliso in her food and she shared the same food with this child and that is why they have the same symptoms. So it was eye opening because from our side we did everything that we could but could not help the child.*

Here it will be seen that not only did Sr. Xoliswa believe, as the child's family also did, that the child had been bewitched, she went on to state how the child would have been possibility bewitched, and that it was through food poisoning. Food poisoning was one way in which a number of the participants felt people can be bewitched, aside from spells or other forms of bewitchments. Sr. Phindile also asserted a similar view to Sr. Xoliswa's view in relation to the possibility of food bewitchment thus leading to a person getting sick.

> *There are some (illnesses) that cannot be related to natural cause, like taking food that is poisoned. That is not natural. Maybe somebody put something in your food. Maybe you eat something that is not meant to be eating. Even with the traditional medicine that might have been gotten from an isangoma. When you eat the food you will become sick and that is also bewitchment (Sr. Phindile).*

Conventionaly, poisoningcan be carried out using any form of medication, ranging from an overdose of prescribed medication to an intake of harmful medication. Here, Sr. Phindile and Sr. Andiswa refered to the form of poisoning made from "traditional" medicine with the purpose of harming one's "victim". Research (Ashforth 2000; Geschiere 1999: 213; Golooba-Mutebi 2005: 938-939; Niehaus 2003: 184; Parish 1999: 430) has shown that in

many African societies, there is still a preoccupation with witchcraft. Writers such as Beattie (1963: 27) were of the expectation that with the inculcation of "foreign" practices and ways of life, known as "modernization" people would desist from their cultural practices such as sorcery. Against this expectation; however, such a preoccupation continues to persist (Ashforth 2000; Fisiy 2001: 227; Moore and Sanders 2003). Dr Fredrick Golooba-Mutebi, a Ugandan Anthropologist and Social Scientist and Stephen Tollman, an Associate Professor of Public Health at the University of Witswatersrand, wrote extensively about witchcraft as practiced in South Africa. They, in one of their writings, asserted that some afflictions are attributed to human agency such as witchcraft, sorcery and poisoning (2007: 66), esepecially within the Zulu culture.

In one of my days in the OPD after assisting Sir Jabulani (Research participant) and a doctor while they performed a lumber puncture on a patient, he narrated an incident to me. He told me of how a patient was brought to the hospital but did not survive, and he (Sir Jabulani) believed that the person was bewitched.

> *We had an incident of a patient here some time back, the patient had a high position at work, and you know the kind of jealousy that is amongst the Zulus, we use traditional medicine to deal with jealousy by attacking people we do not like. So after all sorts of tests and scans we were not able to detect what was wrong with the patient. Unfortunately that patient died. I am sure he was bewitched because of his wealth and the new promotion his family said he had just received from work (Sir Jabulani).*

Sometimes, family members are also accused of having bewitched one person or the other within the family just as in the narrative below told by Sr. Nontokozo (Research participant).

> *I had a gentleman like two weeks back who wanted to commit suicide and was rescued and brought to the hospital. When I asked him what made him want to do that, he told me that sometimes when he is on his own, he hears voices and all of a sudden he felt like killing himself to stop hearing those strange voices. So he took an overdose of medication to kill himself... He said to me that he felt that his granny from the rural area is the real cause because she has bewitched them. That she killed his father and now she*

wants to kill him… So he feels it is some sort of a family curse and I understand him because I have seen those things.

As we continued the conversation about the patient and what she taught about what he told her, Sr. Nontokozo said she knew that the boy was bewitched as she has seen that happen many times. With the skills she had amassed from her previous degree in Social Work and her awareness of the possibility of such situations, she said she was able to approach the patient's situation calmly. "*Becoming a nurse*", however, she said allows her "*to be more practical in helping people rather than just advising or directing them*". Thus, she tried to approach the patient's situation from the living sociocultural reality of the patient, which is a belief in bewitchment- that she also shares.[17]

3.2.3 *"…this is a Zulu thing …the ancestors were not happy"*

From antiquity, a belief in some super natural or metaphysical being has proven to have a great influence on people's ways of life and attitude towards life. Many participants of this research shared views of how they believed their ancestors played roles in inflicting people with pains. Such inflictment is believed to be a form of purnishment from the ancestors to the person for not giving due reverence to the ancestors either through some expected ceremonies or rituals or a warning of something that may befall the person. Sr. Nosipho, whose duty post as at the children's Intensive Care Unit (ICU), told me of an incident which occurred to her child. As I was not supposed to be in that section of the ward, we usually met during lunch at the staff's kitchen or in the main maternity ward.

I have seen an incidence that I did not know what it was at first but later realised that it had to do with the ancestors and it was with my child. She was vomiting, losing weight, and feeling very sick. So I brought the child to the hospital. They noticed that she was dehydrated and we were referred to another hospital for more tests but they could not find anything wrong with her. We were again referred to a higher hospital, they did all kinds of test and they all came back as NAD (No Abnormalities Detected). But what I noted was that her right side was not working. She failed to write. I had to write a

[17] Such a belief is not foreign to me either. Growing up, I heard and saw people who all of sudden became ill and appeared to be in great pains yet their illnesses were not detectable. However, when taken to a traditional healer, they are said to have been bewitched with what is known as *bwa* (lightning). It is regarded as lightening due to the random and sharp pains a victim feels in his or her abdomen (My experience).

letter to their teacher to tell her that she has to understand. She was 14 years then. I could see that it has something to do with traditional things, but I was not sure. Then I had to call the family from her father's side and we sat and discussed about it. They said no, this is a Zulu thing and it is something that should be corrected from the family. So they carried out some rituals and she became well. So they said the ancestors were not happy with some of the happenings in the family that was why. The family did not pay the damages when the child was born and they did not carry out her birth ceremony (Sr. Nosipho).

Sr. Nosipho said this experience with her child, who is now 25 years old and a junior nurse at the hospital, was her main drive to request for a transfer from the main maternity to the children's ICU, where, she said, she is able to give "deep attention" to the children and do her best to see that they are safe.

A narrative by Sr. Andiswa, whom I called "the Children's Angel" due to her fondness for the children, displays a similar circumstance as experienced by Sr. Nosipho's child.

We as parents believe in the hospital treatment, but we also believe that some illnesses are caused by something else and need to be culturally treated. And there are some things that are in our culture that you have to do to a child. When a child is born, at about three months old, you have to remove what is called inyioni. This is done after the first ceremony that introduces the child to the ancestors. So this is to keep the child connected with the ancestors. The child is given herbal enema once a week for three weeks and then the child will grow healthily without any issues. Sometimes when parents complain that the child has hipper pigmentation behind his head, that type of pigmentation is called inyioni and it will get the child sick always. We do not wait until the child is sick before removing the inyoini; we do it when the child is still young. So sometimes when the child is sick, it could be because they did not take out the inyioni (Sr. Andiswa).

Certain ritual ceremonies are performed by *ama*Zulu at different stages of a person's life, such as at birth *(imbeleko*), maturity age and even after a person dies or for certain achievements in a person's carreer. After childbirth, a woman is expected to remain in the house for a period of ten days to carry out certain rituals using a white goat in thanksgiving to the ancestors for enabling her a safe delivery and protecting the baby. In a ceremony I was invited to by Sr. Nelisiwe, she explained to me the importance of having an animal during the ceremony. She said it shows that the person whom the ceremony is been done fore is able to go out of his or her way to appreciate or appease the ancestors. [18] Failure to carry out this ritual is said to lead to many misfortunes in the life of both the mother and the baby (Pauw 1994: 12). Sr. Andiswa asserted that it is common for children to get ill amongst many contemporary *ama*Zulu families because of how many children are not "properly" welcomed into the world, either because they do not know their fathers, or their fathers deny them. She said the cause of this is because many men seem to either "disappear" after impregnating the ladies, or deny fatherhood of the children. Thus, the children are unable to undergo the appropriate initiation ceremony, especially to the father's ancestors. There was also a patient in the hospital that Sr. Andiswa said was suffering from a similar situation because his *inyioni* was not taken out, but they were still waiting to see if the child would respond to any of the treatments they were trying on him.

Another ritual is carried out at the age of maturity of males. This ritual is known as *ukushwama.*[19] Failure to perform any of the ceremonies expected of a person can have a highly negative impact on the person that does not carry out the ceremony. This is believed to be the expected consequence on the person or his/her family as they would have angered or disrespected their ancestors (Vilakazi 1965: 92).

[18] See Appendix 10 with Sr. Nelisiwe captured praying before sacrificing a goat during a ceremony she had invited me to attend.

[19] After this ceremony has been carried out, before a person gets married, several rituals take place during the *ilobola* (bride price) negotiation process. This particular ritual is believed to create a strong bond between the new couple and to serve as an introduction of the couple to the clan's ancestors (Pauw 1994: 13). Vilakazi (1965: 91-92) also notes that certain rituals take place after a person dies. There is the slaughtering of a goat by the family and a farewell ceremony known as *hlamba izindla*, performed a week after the person has been buried. This ceremony is followed by *zilela ofile*, another ceremony carried out a month after the person's burial. He also noted that there is a final ceremony known *as buyisa*, performed a year after a person's burial day.

Within the Zulu culture and many African soceities, ancestors are generally regarded as the "living dead" members of a clan based on their supposedly active role in the lives of the living-living clan members (Buhrmann 1984: 27-28). Thus, the concept and belief in ancestors has psychosocial dynamics which impacts on the everyday life of people who belief in their existence (Edwards *et al.* 2009: 1). As stated by Bogopa (2010: 1), "ancestor worship is founded on the belief that the dead live on and are capable of influencing the lives of those who are still living. They are capable of both blessings and cursing those who are still living".

The extent to which ancestral belief is embedded in the life of African people is that to which it is able to influence their health-related attitudes. Thus, "one cannot talk about health in South Africa without acknowledging the reality of ancestral belief" (Bogopa 2010: 1). The research participants gave me the impression that belief strongly in ancestors and in the possible role they play in the lives of the soceity. Many of the participants spoke about the ancestors as being a part of them.[20]

Edwards *et al.* (2009: 3) asserts that "there exists an "intimate relationship between the living and the dead" and it shows itself in how much revernce is given to concepts such as *umphefumulo* (soul), *umoya* (spirit) or *isithunzi* (shadow). The ancestors, says Edwards *et al.* (2009: 4), hover over their living descentants, and that is known as *ukufukamela*. Also, Bogopa (2010: 3) states that the "Zulu-speaking people believe that if a particular ancestor had a temper (*enolaka*), he would come down with great harshness when he felt offended". This punishment can be an illness, an accident, or a lack of progress in one's job or profession (Buhrman 1989). Although the ancestors may not directly inflict any pains on people per say, but by taking away the protection they gave to the people, people are left exposed to numerous misfortunes such as violence, drought or even a decrease in health (Adams 1999).

[20] Such a concept brings to my mind the reality of having to be away from a loved one yet believing that the loved one is looking after me even if they are not alive or physically close by. Such thoughts and feelings arise to me particularly when something good happens. I simply look up to the sky and say *mafeng a gwei* (thank you grandma), for praying for me, because I believe that although she is dead, she prays for me and her prayers are heard by God. Such an intercessory role is what many of the participants viewed as being played by the ancestors.

While some illnesses are regarded as a curse from the ancestors due to one's failure to carry out a ritual, some illnesses seem to come as a sign to show that a person has been "specially chosen" to follow the cultural path of becoming a *healer*. Sr. Andiswa who is married into a "traditional" family[21] narrated how her child was "chosen".

> *Something happened to my child who is now 3 years. After his birth, he was just normal, and then at the age of 18 months, I found out that the fontanel was still open. So I went to the doctor and the paediatrician said let us go for a scan. The results came out and it was declared hydrocephalous, but it was non communicative hydrocephalous. Then I talked to the family, my in-laws, and they said no, this is not hydrocephalous. It, being hydrocephalous means he needs to be taken for an operation to put up a shunt. So the family said no I do not have to go for an operation. That this normally happens in the family when a child in the family is "chosen" until they are entrenched (referring to the indoctrination of the child into the family's cultural practice). There are some kids in the family who had the same problem and you have to consult the family's isangoma first before you even go and do whatever operation you want to do. Now we are doing the rituals for the whole of this year.*

Although signs to know if a person is chosen or not, differ, usually some unusual circumstance occurs such as illness, persistant dreams or nightmares, and sometimes accidents, especially if a person does not want to respond to the call to be a *healer*. As Ngubane (1977: 102) asserted, in *Nguni* culture, "a person does not choose to become a diviner, but is chosen by her [sic] ancestors, who bestow upon her [sic] clairvoyant powers". It is expected that the person carries out a rite, which can last for several months as a way of accepting and being trained in the "ways of the healers". The ritual of accepting the call is known as *ukuvuma idlozi*, which "implies death to the old way of life by undergoing training to be "reborn", *ukuthwasa* (Edwards *et al.* 2009: 4).

[21] By this I mean that is a family which holds and practices cultural rites and has some members who are "traditional" healers.

It has been asserted that many African societies, including the *isi*Zulu-speaking communities, are of the belief that there exists a cosmological and hierarchical relationship in the universe (Parle 2003: 107). This hierarchical relationship is arranged in this manner: "a ruling deity, less powerful spiritual entities, ancestral spirits, living persons, animals, plants and other objects" (Truter 2007: 57). Placide Tempels, a French philosopher who lived in Congo and who wrote extensively on Bantu Philosophy, attempted to analyse this linear relationship and the notion of being and existence within the African setting. He introduced the notion of 'vital force', referring to some form of strength and power that is enshrined in each being (Tempels: 1959: 58). This power, he claims, makes African people capable of a to and fro relationship in the universe. The 'connective' effect of vital force confirms the African ideology of an interconnected and harmonious rapport between all existing beings. Like a spider's web, beings are attached to, and necessarily influence each other. Thus, a person's or being's vital force can be used to increase or diminish the force of another. Valenkamp and Van der Walt (2006: 11-12) also wrote about this metaphysical connection that exists within beings when they said that the cultural or "entrenched" aspect of the human person, involves the spiritual realm. This cultural aspect and belief in an interconnectedness of beings contributes to the amplification of the bio-psychosocial model to health, as asserted by Valenkamp and Van der Walt (2006: 12). Thus, amongst the *ama*Zulu, illnesses are often attributed to a spiritual or social cause, and a person can be made ill by another through witchcraft and sorcery and not only physiological or biological (see Naidu 2013: 253-254; Naidu and Ngqila 2013: 128) . Understanding the connection between the health of a person and his or her relationship with other beings is crucial to both eco-systemic anthropology and traditional medicine. Eco-systemic anthropologists are of the belief that a dysfunction in the relationship can bring a misbalance in a person's health (Kirsten *et al*. 2009: 6).

These narratives and beliefs display how people's reverence of the ancestors and the supposed connection between the living and the dead can have on people's daily well-being and activities. The narratives and stories portray how the *isi*Zulu-speaking nurses regard the environment, the ancestors and other community members as factors that can be connected to ill health state. This ill health, as shown in this chapter, can be physical, spiritual, emotional or social, causing disharmony between the person and his/her ancestors or other members of the community (see Cumes 2004: 90, Golooba-Mutebi and Tollman 2007: 65-66).

3.3 Conclusion

These narratives and experiences show that cultural factors cannot be done away with in diagnosis, treatment, and patient care as they contribute in shaping patient's and nurses' health-related beliefs, behaviours and values (Kleinman and Benson 2006: 1673). Biomedicine, however, has over the years attempted to overlook the possible impact of cultural beliefs on patients and nurses' health beliefs and values. Tomlinson (1999: 26) suggests that in dealing with health-related issues, there is a need to consider cultural factors because globalisation "is not a 'one-way' process of the determination of events by massive global structures, but involves at least the possibility for local intervention in global processes". Thus a thorough consideration needs to be taken of how nurses' explanation of aetiology and patients care is being influenced and affected by their cultural constructions of health and illness (Finkler 2004: 2037).

In this chapter, I have attempted to explore *isi*Zulu-speaking nurses' understanding of illness and healing. The captured narratives in this chapter showed how some of the nurses had strong beliefs in the cultural approach to health. These beliefs have either been shaped by their upbringing, or their personal experiences or those of their close relatives. As such, they have particular understandings of what it means to be sick, which have been shaped by both the biomedical training and their cultural beliefs and practices. Some of the beliefs, as seen in the chapter, are the belief in the interconnectedness of all beings and that all beings are able to influence each other. The participants also expressed a belief in ancestors, witchcraft, and the role the environment as contributory factors to determining people's state of health. Thus, it is inevitable that such beliefs, to a large extent, shape their understanding of biomedicine and its practice within the hospital space

CHAPTER FOUR

Being a Nurse *and* an *iSangoma*

4.1 Introduction

One's way of life and beliefs can, to a great extent, shape how one approaches his or her reality, even at one's "professional" workplace. *Isi*Zulu-speaking nurses, as shown in the previous chapter, have certain ideas and notions of health and illness that are greatly influenced by their cultural view and approaches to health and illness. Further to being an *isi*Zulu-speaking nurse, some of the participants in this study were also practicing traditional healers, also known as *izangoma.*[22] As such, while other participants in the research had cultural understandings of illness that have been shaped by the Zulu culture, its beliefs and practices, the *isangoma* nurses are fully involved in these cultural healing practices. As asserted by Kale (1995: 1182), "traditional healers existed in South Africa before its colonisation by the Dutch in the 17th century. They have flourished in the face of competition from modern medicine. About 200,000 traditional healers practice in South Africa, compared with 25,000 doctors of modern medicine; 80% of the black population use the services of traditional healers". This is because, he claims, "traditional healers are enshrined in the minds of the people and respected in their community, and they are often its opinion leaders" (Kale 1995: 1182).

As asserted by Gourley (1995: 2), nursing is an important job which requires much dedication and should be regarded as a vocation rather than a job. This chapter looks at the particular views shared by the *isangoma* nurses in this study towards health and illness. The views shared by them are derived from the lived experiences of the *isangoma* nurses as practicing nurses and *izangoma.*

[22] A plural term for *isangoma*.

4.2 How the *iSangoma* Nurses View Illness

> *The human person is so full of energy. This energy is within us and around us. It makes us have an influence on each other and nature also communicates with us through this energy. So depending if a person allows the flow or not. When we allow the energy to flow freely, then we are healthy and have a peace of mind, but when there is an interception in the flow of energy within and around a person, there will be chaos in the person or the community and that can lead to even physical chaos. That is what I will call being unwell because there is nothing like illnesses. It is only this chaotic state that can lead to a person even having physical pains or symptoms (Sr. Mpume).*

As I have earlier stated, there is a strong reverence for interconnectedness within the African society and any danger posed to any string of the connection can lead to instability within the system, made up of the living, the dead and the environment.

> *For a person to be sick it means that the person is physically not fit to do the normal things that he or she is used to. Usually it is physical but it can be because of a spiritual problem and sometimes it has to do with what one might have done or not done to the ancestors. You need to take the history, you need to sit with the person and find out what has been going on for them (Sr. Nelisiwe).*

As seen in the narratives shared by Sr. Mpume and Sr. Nelisiwe, the *izangoma's* perception of good health is linked to the presence or absence of a "harmonious relationship with the individual, and nature, with emphasis on interpersonal relationships" (Watts 2010: 18). With that being the case, health in this case will be regarded as cordial unification in all the aspects of the human person with his or her environment and the ancestors (Moodley 2005). Ill health, on the other hand as asserted by Watts (2010: 19), will be the existence of disharmony in a person's holistic realm, physical, spiritual, psychological and otherwise. This disharmony is said to lead to frustration, anxiety, isolation, confusion. The meaning of illness as asserted by the *isangoma* nurses, although similar to that of other nurses in this

study, showed deeper cultural explanation due to their skill in what I will call the "sacred".[23] Sr. Nelisiwe for instance, who is a recognized and practicing *isangoma* and a head of one of the units, revealed an understanding of illness that seem to be shaped by not only her nursing profession, but also her cultural profession as a healer. Sr. Nelisiwe did not only portray different attributes to illness such as physical and psychological, but also spiritual (ancestral). Her views were well respected within her unit and she said she was born to "…*help people, to heal, to love sick people"* and that from an early age, she was able to know when something is wrong with a person even without the person telling her.

Narrating how she was able to know what a patient is suffering from and if that illness simply needs the medical attention offered in the hospital or needed more assistance that she could offer as an *isangoma*, Sr. Thabile asserted:

> *For us (izangoma) there are so many ways of knowing what a patient is suffering from. For example if I walk pass OPD and there is someone having sharp pains, I immediately pick it up by having those sharp pains. So I actually feel what someone else feels. Some of them will just understand when I immediately say oh the sharp pain. Then immediately going away from them I would have partly healed them because I would have taken away what they have... There was once a time I was doing my rounds in OPD, I passed by this patient and I was like what headache. I was like what excruciating headache and I knew it was not okay but that was because one of the patients was feeling that much headache.*

These narratives express the unique understanding of illness and the *isangoma* nurses' ability to "detect" what type of illness a person is suffering from and from there decide on what steps to take in order to assist the patient. The self confidence amongst the *isangoma* nurses and the impact of their practice was phenomenal as they asserted how they were able to know the difference in illnesses.

[23] By "sacred" here I refer to the role of being a cultural healer amongst the *ama*Zulu, which can be as a *isangoma*, *amaproheti*, or *inyanga.*

> *There are some illnesses that may not be linked directly to any natural causes and the medicine for that has to be from the traditional healer. Even those of natural causes like urinary tension; there is medication for such in the Zulu culture. When a person has that, he [sic] is taken to the traditional healer who will use his eraser to cut into the area that is affected. So most times we first go to the traditional healer and hear what he has to say before we can even think of going to the hospital (Sir Jabulani).*

This assertion shared with me by Sir Jabulani a well-respected nurse in the OPD shows the shared reality of many of the research participants who had similar views. They viewed illness not only from a physical or biological perspective, but as a possibility of interconnected phenomena or realities that might have tampered with the person's spiritual or even physical wellbeing. As asserted by Mazama (2010: 7), because African people such as the *ama*Zulu, view a person as a combination of different interconnected components such as physical and spiritual, "what may appear to be a physical ailment, because of the physical symptoms and illness, often turns out to be a spiritual illness". Hence; in "curing" an ill person their spiritual imbalance will have to be addressed- if physical and spiritual health is to be attained.

Health seeking behaviours, as stated by the nurses are of various dimensions. The behaviour or behaviours sought are subject to the type of illness and the health belief system of the ill person or his or her caretakers. Many of the nurses expressed a deep belief in the traditional healers when faced with certain illnesses. Different approaches to treating illnesses are employed by different societies. Generally, says Ivey, Andrea, Ivey and Morgan (2002: 12), people resort to religion and spirituality for healing. South Africa, as asserted by Wreford (2005: 55), "has a pluralistic system of health provision". The traditional approach, the biomedical approach and the spiritual approach to health are the most sought means of treatment within the country (see Wreford 2005: 55; Kirsten 2009: 1-2). In line with what Sir Jabulani shared, research (see Louw and Pretorious 1995: 43; Peltzer 200: 60-61) has shown that many South Africans when ill, resort to traditional healers as their first line of help before attempting other means.

When asked her opinion about the health seeking behaviours and what she has observed, not just in the hospital but even around her community, Sr. Nothando said *"people always rush for the traditional treatment where people are examined by throwing bones and then they (healers) conclude on what is wrong with the person".* She went on to narrate how her father sought the treatment of a traditional healer when he was ill.

> *…like my father, he had a stroke in 1997; his whole left side was not functioning. While he was admitted at hospital then, we visited him and he told us that he needed to go out of the hospital. That he had been told by the ancestors that he needs to get out of the bed and go to a certain place where he will meet a certain traditional healer who will give him the mediation he needed and he will get well. He did exactly that and today he is well and you will not even say he ever had a stroke. But he still takes Western medication to control the BP (Blood Pressure) because that was what caused the stroke. You will find some people say I had a dream and I am supposed to go see this person or mix this and that leave. And when they get to the traditional healer, you will find out that the person (traditional healer) will say "I have been waiting for you for so long", because they know that there is a patient who is coming there.*

Here, despite the faith Sr. Nothando's father had in cultural medicine, which made him leave the hospital and its subsequent aid in his "healing", he still makes use of biomedical medication. According to Golooba-Mutebi Tollman (2007: 65) "people react to illness in four ways: they do nothing and wait 'to see what happens'; self-medicate; or visit clinics, hospital, and traditional therapists". Depending on a person's worldview however, a person may make use of two or more of such reactions when they are ill either one after another or simultaneously (Bierlich 2000: 705) as it was the case with Sr. Nothando's father. He made use of a cultural means of healing in place of the Western treatment he was receiving in the hospital, yet he still uses Western medication to maintain his BP. As propounded in the Health Belief Model (HBM), a model which was developed from Lewin *et al.'s* (1939: 270) idea, a person's actions on what he or she will do or not do are determined by their socio-cultural world. HBM promotes the prediction and understanding of people's health-related behaviour based on certain belief patterns (Hochbaum *et al.* 1952: 2), especially those accumulated through their societal norms and practices.

In Peltzer's 2000 studies in the Limpopo Province of South Africa, it was discovered that out of 104 black Africans sampled, 68% sought medical treatment during their last illness. 19% of them visited the herbalist for both minor and chronic conditions. 9% had been to the diviner, while 4% had gone to a faith healer Peltzer (2000: 60). As far back as 1998, Wilkinson and Wilkinson (1998: 737) conducted a study in a KwaZulu-Natal primary health care clinic and found that out of 360 patients diagnosed with STIs, 14% had sought treatment from a traditional healer. Similar to this finding, in another study also conducted by Peltzer, the healers asserted that they were often consulted to treat "sexually transmitted infections (STIs) such as *Tshofela*/drop (gonorrhoea), *Thosola* (syphilis) and assumed HIV/AIDS" (2001: 4). In 2003 Peltzer also found out that about 36% of rural South African adults who had suffered some form of STIs within 12 months of the study, had sought treatment from traditional healers (2003: 252).

There are three main types of traditional practitioners that are consulted within South Africa. They are the *inyanga*, who is mostly a male and makes use of herbs for treatment; *isangoma* or diviner, mostly a woman, and she uses traditional religious supernatural powers to communicate with one's ancestors; and lastly the faith healer who is also known as *amaprofeti*, who integrates Christian practice and tradition Zulu practices (Freeman and Motsei 1992: 1183; Ivey, *et al.* 2002). The healers supposedly treat the person as a 'complete being', mind, body and spirit through psychological, physical, spiritual and social diagnosis using supernatural powers to decipher what is wrong with the person (Truter 2007: 58). Such form of treatment is also known as the bio-psychosocial perspective on health and the body. The role of the traditional healers, as Madamombe (2006: 11) stated, is to "facilitate communication between the living and the dead"…. The traditional healers are also "reputed to divine the cause of a person's illness or social problems by throwing bones to interpret the will of the dead".

Thus as the above studies reveal, traditional healers are visited for both mild and life threatening illnesses. Although traditional healers operate in a similar manner and sometimes overlap each other's approach, they all have their 'unique' gifts and manners of operation (Cumes 2004: 14).

Although both Sr. Nelisiwe and Sr. Zama say they are "strong" Christians, they are also healers within the Zulu culture and have in-depth knowledge and experience about what goes on in a "traditional" healer's "consultation room". Their knowledge, aside from sprouting from their observations and stories shared by their patients, also came from their personal experience. While Sr. Zama started off as a cultural healer before converting to Christianity, Sr. Nelisiwe said she has always been a strong Christian before she underwent her initiation rites in becoming an *isangoma*. An *isangoma* may be consulted for treatment of an illness such as body aches, stomach aches, to issues bothering the community such as a cleft between community members and the ancestral spirits (Adams 1999). The steps and action taken by a traditional healer when visited is known as the *vumisa* (literally meaning to persuade) technique. Although some healers carry out diagnosis in their peculiar way, divination; however, as stated by Gumede (1990) follows the *vumisa* technicque:

> …the *vumisa* technique is where the diviner, following appropriate communication with the ancestral shades, tells the afflicted of the illness, honing in on problem areas depending upon the degree of expressed agreement by afflicted and relatives before giving advice or treatment, which is typically of a religious and ritual nature.

This technique was also familiar to other *isangoma* nurses but in different ways. This approach is called the *vumisa* technique due to the belief that by chanting the incantations and throwing the bones, the healers praises and at the same time subtly persuades the patient's ancestors to tell or *show* him what is going on in the patient's life and how he (the healer) can help the person.[24]

Sr. Zama often invited me to her office for a cup of coffee while we chatted about many things including my study, her work, and other casual conversations; hence, I was able to notice the Crucifix and the framed picture of Mary (mother of Jesus) in her office. She told me about some of the medications given to people when they visit her at home as a "traditional" healer and how she comes to the conclusion of what medication needs to be given to a person. She said she seats the person, begins chanting while she throws her bones. After throwing the bones, whatever position each bone falls into, the healer believes that such

[24] See Appendix 11 with where I captured Sr. Mpume showing me how she sits when about to begin the prayers. She said she has to keep her head low as a sign of respect for the spirits that communicate with her during the session.

a position has been decided by the ancestral spirits and has its unique interpretation and meaning (Walter 2004). Within the contemporary biomedical sphere, however, as stated by Sir Nothando *"the individual will sit with the doctor and say this is what is wrong with me and this is what I am feeling and all that and then the doctor will do the investigation and come up with the diagnosis"*.

Edwards (2009: 3) states that the *vumisa* technique is essential and focal to diagnosis by an *isangoma*. As stated by Sr. Nelisiwe, Sr. Mpume and Sr. Zama, the healer does not work in isolation in determining what the patient is suffering from. They communicate with the spirits, the patient's ancestors, or what Sr. Nelisiwe called her angel through the chants they make during the consultation. Noting this collaboration between the physical being (the *isangoma*) and the unseen being[s], Adams 1999 asserted that "in understanding Zulu traditional healing, it is imperative to recognize [that] the *izangoma* him or herself do[es] not actually *provide* the solutions to the problem on their own. The ancestral spirits they have access to, provide them with guidance while the true role of an *isangoma* is to communicate the message from the ancestral spirit to the client". This power to communicate with the unseen beings was alluded to by one of the research participants.

> *When I listen every day I hear things that I have never known before so I expand every day. The universe is moving, things are moving, time is moving. When I listen, they (the unseen spiritual beings) tell me and I see each and every plan that the world is projecting towards where the world is getting into. I know exactly what will happen next year because I am aware of the energy shifts. What the weather is saying, what the sun is saying, and what the moon is saying and know exactly how it is going to happen. And I know which energy has been suppressed and I know which one is going to come out (Sr. Mpume).*

Sr. Mpume here said she "listens" because it is believed that, aside from the inspiration or communication that may take place between an *isangoma* and the spirit world while chanting during a consultation; they are also communicated to through the winds. Walter (2004: 957) asserts that the spirits communicate with the *isangoma* or the *isangoma's* clients in form of a whistling voice, but because not all clients can listen, hear or interpret these voices, the *isangoma* listens on their behalf. Whatever type of divination is carried out, it is said to be the

responsibility of the *isangoma* to communicate to the patient what message the spirits have in store for the person and what is to be done to resolve the disharmony that has led to the ill state of the person. The healer would then prescribe/communicate to the client what rite he or she is to carry out, what herbs to use, or present them with water, depending on what the spirits decide and on what type of "illness" the person is suffering from (Moodley 2005).

4.3 Healing Rituals using Animals

> *In cultural medicine, it's not always medicine, medicine. Yes its medicine when necessary and when its medicine its natural herbal medicine. But most of the time, because this whole person comprises of not just the physical body which is anatomy and physiology, but comprises of the forces that govern our lives or the soul. When I say the essence of my being, it also comprises of my relationship with those who are departed from my family. We respect that they have a link with us. Most of the times you will find out that it is not a physical illness. But this body of mine, in its holistic form, has been alienated from its natural space. Now it is fighting to get back into that space in order to be able to function normally because out of that space it is suffering.*
>
> *When a person is having a headache it is when we block the thought process in us yet we go take some panadols and when you get to an isangoma they give you muti and it clears the blockage and you are able to clear the blockage and you are sorted out. Meaning the energy that wanted to come in wanted to do something and clearing the migraine allows the energy to flow into you (Sr. Mpume).*

Just as in any known form of medical treatment, spiritual or biomedical, there are different prescriptions for different illnesses in the Zulu cultural treatment as administered by the Zulu healers, based on the type and intensity of the illness. While some illnesses may require a person to consult an *isangoma* or an *inyanga*, some illnesses simply demand that a person carries out certain rituals or sacrifices to get healed. Even after consulting an *isangoma*, a person might not be given herbs, rather, might be told to carry out a certain rite using one animal or the other in order to appease the ancestors- before being healed. For instance,

Sr. Nontokozo told me of how her daughter was once ill, and all they did was to carry out certain rituals and tied a string, received from the *isangoma*, around the girl's waist and she became well.

> The cleansing rites of illnesses, usually involve appropriate sacrifice of an animal, mostly a goat, washing in chime, usually from the intestine of the animal killed, keeping off from glamorous looks of clothes and cosmetics, and wearing a piece of the slaughtered animal's skin around one's wrist. After the sacrifice, one may be expected to cleanse or drink from a gall. It is believed that the ancestors love the sweetness of the gall (Edwards 2009: 3).

Rituals are sometimes recommended by the *izangoma* after consulting a patient because they believe that not all conditions require medications. Sr. Mpume regards a state of being ill as *"an interception in the energy flow within and around a person".* She asserted that people need to allow the flow of the supreme energy in their ecosystem without any interference. However, different materials such as bones,[25] water, herbs, sticks and stones are used during rituals. Depending on the *isangoma* and their particular calling, one or more of these tools are used during a consultation or recommended to be used after the consultation during any prescribed rituals.

4.3.1 The use of herbs

> *I use different herbs when treating those who visit me. When treating them, the herbs supress any illness that the person might be suffering from. The rituals I carry out may also send back the curse if the person might have been cursed and to cleans them. And whenever I treat a person I expect a holistic healing (Sr. Thabile).*

> *So I have mutis like uhlungu hlungu. You mix that when you are doing amazan nyama. That is when you helping msamo wahke, that is a person has died but is not yet part of the family in spirit especially if they were not good people or died in an accident. So you bring their spirits into the family.*

[25] See Appendix 9 which captured Sr. Mpume showing me how she throws her bones.

> *I also use qumba in the second phase of the ritual. It is done in three faces for 21 days. For the first face, you steam then you bath the person for seven days and after the last seventh day you do the slaughtering to the ancestors and the ceremony is completed and the ancestor becomes a part of the family (Sr. Nelisiwe).*

The use of herbs is almost generally acknowledged within any African cultural healing rite. These herbs as Sr. Nelisiwe showed me in one of my visits to her home are derived from leaves, barks of tress and their roots. They may be fresh when given to the patient, or dried, ground and mixed with water. Plants have served as a great source of medicine and till date, many medicines are derived from natural herbs or sources (Balandrin, Kinghorn and Farnsworth 1993). The "welcoming" of the ancestors' ceremony referred to by Sr. Nelisiwe has been extensively described in another study by Edward *et al.* (2009: 6). They state that due to the continuos relationship with ancestors within the African setting, when a person dies, especially in an acident or at the hospital, he or she ought to be given a befiting burial by carrying out a rite in order to be regarded as a member of the *abaphansi* (living dead). Whenever such an occasion is not carried out, it is believed that such a person remains an outsider in the communion of the family's *abaphansi* and is sometimes regarded as a ghost or "bad" spirit and haunts, taunts or is unable to protect the family members from any ills. In order to welcome such a person into the communion of *abaphansi* and allow them their place as ancestors of of the family, the appropriate rites are conducted. An important aspect of this rite is the use of *ilhahla.*[26]

[26] This occasion is comprised of the slaughtering of an animan whereby *isisihlahla* - a type of twig from a tree known as *umlalhamkosi,* is used in creating a communication channel between the deceased member of the family and the living. During this ceremony, an elderly family member of the deceased is assigned to tie the twig using a thread while communicating with the deceased person, informing him or her that the family is there to take him or her home from the place he or she died to his or her family home. The person carrying the *ilhahla* is not allowed to speak to anyone on the way aside from the deceased. Thus, there is a spokesperson who accompanies him or her in case a need arises for any verbal communication with someone other than the deceased (Edward *et al.* 2009: 6-7). The use of this particular twig is regarded as important because the communication that takes place between the family's elderly person and the deceased during the ceremony.

This dependence on plants, as many studies have shown (see Farnsworth 1994; Srivastava, Lambert and Vietmeyer 1996: 18), has continued to play an important role in health care and traditional rites, especially in many African countries. Thus, herbal therapy, as stated by Banquar (1993), although not written down in many societies, is well established and used by almost 80 per cent of rural dwellers, especially in Africa, Asia and Latin America. According to Aitken (2003), the effectiveness of herbs such as *Gingko biloba* and *Borneo* used in treating memory loss and malaria respectively has been shown by pharmacological studies. Despite the lack of trust in some traditional herbs (see Kale 1995), Hammond-Tooke (1989) earlier, stated that although it is difficult to explain *why* and *how* traditional medicine work, their effectiveness cannot be doubted. Healing, he claimed, may be due to the derivation of meaning together with the sense of comfort and fulfilment the patient derives from the treatment- even when a cure is not found for his or her illness (Ross 2007: 18).

In a study conducted by Bierlich (2000: 705) entitled "Injections and the Fear of Death" that focuses on the Dagomba of Northern Ghana, he shows that there exists a condition known as *kpaga,* which is similar to an ailment known as *mbande* (amongst the *ama*Zulu) and *xifulana xifula* in other parts of South Africa. This condition literally means a band, due to the feeling of a rope being tied around one's waist. The condition usually portrays symptoms of stroke and septicaemia. It also comes with severe headache, stomach-ache, swellings and wounds on the body (Golooba-Mutebi and Tooman 2007: 66). It attacks a person when he or she jumps or steps over some medicine that might have been laid along his or her path by someone that dislikes them. Bierlich (2000: 709) discovered that amongst the Dagomba of Ghana, which is also similar amongst *ama*Zulu, if such a condition is treated by hypodermic injection, which is the proper biomedical treatment, a person could suffer sudden death. Thus a person suffering from *kpaga* has to be immediately rushed to a traditional healer who will give them certain herbs, and likely tell them who bewitched them.

4.3.2 The use of water

> *Sometimes I pray over water and mix it with some powder and give them and sometimes I give them candles. It depends. But most of the times I do not just decide what to give a person on my own. It is my guides who will tell me what I should give to the person. So my angel can decide to say give this person this medication or that, or take her to the river and do this or*

that. I use both. I use my angel, we call it isitunywa, and I use illungoma, my ancestors. Right now use abalozi amakhosi apheZulu, these are ancestors who talk to you in the wind or use sounds like whitsling but I will be the only one who will be able to hear them (Sr. Nelisiwe).

Although when a person comes to me I can even hear what is wrong with them even before they come. I can bless water and give it to them or by just talking to them I am able to redirect their thought flow to make the negaive energy that had caused them the problem flow out of the person.

I was not given herbs to heal. I was given water. We are about 80 per cent water. So water is very powerful and the water that we are combines with other rivers and that is why whenever something is happening I am able to hear because the water connects us and I am like the sea which all the water from the rivers connect to (Sr. Mpume).

The use of water, although not very popular amongst many healers, remains vital in the lives and healing processes of the *isangoma* nurses in this study. Sr. Mpume for example, said even though she can make use of herbs, she prefers to make use of water as that is the material through which her guardian (spiritual) gives her power when she needs to make a direct contact with a person, or prescribe something to them.

While most people go to a healer for consultation and treatment, others carry out the treatment themselves believing that they know what is wrong with them or the ill person. In one of the days I spent in the Paediatric Ward, Sr. Andiswa told me about some self-medication habits that people carry out, including her and her mother-in-law, especially on children.

They (the patients) also interpret stroke or meningitis as isilonda. When a child has collapse they call it isilonda. When a child is weak and not playing, they call it isilonda. So what they do is that they mix Colgate toothpaste, black shoe polish and umpukuthu, roll it on the thumb and put it in the baby's anus and the child will resuscitate immediately. What my mother used to do is that she didn't use the black polish, she used Colgate, Disperene and put it in the children and it works. Even when a child is having common cold or fever, even when you are trying to give Panadol and all that, she just takes the baby away.

Even my mother-in-law does that too with my baby and the child becomes alive. But sometimes even when the child is really sick they confuse it and say it is isilonda (Sr. Andiswa).

Another form of self-herbal medication used by patients in the hospital is known as *isihlambezo*.[27] This medication is mainly used by pregnant woman during their pre-natal period. Sr. Phindile who had worked in the maternity ward for over 20 years narrated to me some of the many incidences she has encountered of pregnant woman taking the medication before getting into labour.

In maternity (wards) there are some patients using traditional medicine. You know there is this thing called isihlambezo. Isihlambezo is some traditional medicine that is believed or intended to hasten or fastened labour. So they believe that when you take isihlambezo your labour will be quicker. They even believe that your baby will come quickly without any problem.

The practice of taking *isihlambezo* and the reasons behind such was written about by Naidu in her in-depth study of 15 Zulu women around Durban in 2013. Similar to what Phindile noted, one of Naidu's participants said taking *isihlambezo* protects *"both the baby and its mother from any harm during pregnancy"* and because some people may harm the mother or the baby, *"using isihlambezo protects you from all this. It covers the baby from all sorts of sorcery and bad luck"* (Naidu 2013: 256).

4.4 Conclusion

Based on recent research, it has been shown that healers themselves are of the belief that an there are internal and external forces that are at play during healing and through their healing power (Lumbsden-Cooke, Edwards and Thwala 2005; Lumbsden-Cooke, Thwala and Edwards 2006). Re-enforcing this view, Edwards *et al.* (2009: 4) states that such ancestral ceremonies bring about a re-establishment of both "archetypal and psychodynamic harmony".

[27] According to Kaido, Veale, Havlik and Rama (1997: 186), *isihlambezo* is a tonic "taken by pregnant women from the sixth month (of pregnancy)". According to them, "…women grow the plant in water and drink some of the water, night and morning, from the fourth or fifth month of pregnancy, with three objectives; to ensure a healthy child, to ensure that the child will not develop bowel trouble, and to ensure that the placenta will be delivered without difficulty" (Kaido *et al.* 1997: 186).

This harmony is brought about between the ill patient, the healer and spiritual forces; thereby bringing about a balance in people's familial and their ancestral heritage. Such practices may remain oblique and ancient to many in the "modern" world, but as Edwards *et al.* (2009: 5) asserted, "whatever the level and type of scientific explanation for divine mediation, research supports the psychotherapeutic effectiveness of traditional Zulu healers and ancestors as healers". Thus, after any healing procedure, a person does not only become physically well, but is able to gain some sense of rootedness by feeling protected and gaining a renewed sense of identity. As asserted through Dubos's (1959: 3) definition; health is generally regarded "as the absence of sickness" which leads to "a state of physical, social, and psychological well-being".

Isangoma nurses have some knowledge and experience about health and illness that may be considered unique and highly enshrined within the Zulu culture. Their knowledge, as asserted by Shale, Stirk and van Staden (1999: 350) and the *isangoma* nurses, is received from the gods and their experience with their patients and shared ideas with other healers. While some healers may make use of herbs, bones, stones or even sticks, others make use of water or together with the other mentioned materials. The process of diagnosing their patients, however, is very similar despite the type of material used by the healer. They all allude to what is known as the *vumusa* technique whereby they make incantations, communication with the patient's ancestors and their (the healer's) guardians to inform them on what is wrong with the patient and on the form of medication to prescribe. Whatever the prescription or rite recommended for treating a person by the *izangoma*, being healthy is what they aim to achieve for their patients, and "being healthy" as stated by Mazama (2010: 7) means "enjoying balance in [in one's] physical, mental, psychological, material and emotional realms". Having such a culturally knowledgeable part of the population working as nurses within the hospital space, provided this study with a "more cultural" angle to how *isi*Zulu-speaking nurses negotiate and renegotiate their identity within the hospital in patient care.

CHAPTER FIVE

How Nurses' Understandings of Illness Shape Patient Care

5.1 Introduction

The responses to patients' illnesses involve a variety of decisions by nurses and other clinicians, which can be otherwise termed "clinical judgement".[28] This chapter explores how nurses' understanding of illnesses and health shape their approach to patient care (clinical decision) within the hospital. The chapter flows from how nurses are able to notice and group patient's illness to how nurses' personal understandings of illness contribute to their clinical decision-making. Nursing, has been described as a profession that makes constant use of "clinical judgement" (Royal College of Nursing 2003: 3), and involves the use of one's knowledge, experience and conscience in taking actions in any clinical setting. This means that the goal of any clinical decision taken by a nurse, are not only important in themselves but how they contribute to the wellbeing of patients. The end result is to always strive to promote a better state of patients' health.

The decisions taken by nurses are shaped collectively by their educational training, nursing experience, life experiences and personal beliefs. As seen in previous chapters, *isi*Zulu-speaking nurses have a wide understanding of illness, part of which is shaped by their cultural upbringing; thereby giving them particular cultural understandings of health and illness. Thus, understanding the context in which nurses carry out their decisions and what shapes such decisions, as asserted by Harbison (2001: 127), is important. Arriving at any stage of clinical judgement requires sometimes a rigorous, and sometimes a quick process of reason. Tanner (2006: 204) asserts that this process includes the "deliberate" process of creating alternatives, weighing them in comparison to any available evidence, and in the end making a choice that will be considered most appropriate towards the promotion of the patient's health.

[28] In this study, the term "clinical judgment" will be used interchangeably with the term "clinical decision". Clinical judgment has been defined by Tanner (2006: 204) as "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decisions to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response".

5.2 How Nurses Notice and Group Patterns of Patients' Illnesses

I have a child who is now 3 years. After his birth, he was just normal, and then at the age of 18 months, I found out that the fossil is still opened. So I went to the doctor and he was scanned. The results came out and it was declared hydrocephalous, but they said it was non-communicative hydrocephalous. Then I told my in-laws and they said no, this is not hydrocephalous. It being hydrocephalous means he needs to be taken for an operation to put up a shant. So the family said no I do not have to go for an operation. That this is normally what happens in the family. There are some kids in the family who had the same problem and you have to consult an isangoma first before you even go and do whatever operation you want to do. So we went and we did all the cultural things that I needed to do because I had to clear my conscience and be sure of what I was doing. After they finished I went back to consult the neurologist and was booked for an operation. But when we went for the operation, the child was sedated, and whenever they wanted to start the operation, he just wakes up and sits there for the whole day. That happened on two more visits even when he was given a stronger sedation. Then we went back home and the family said "no ways". That this shows that there is something more that needed to be done as a family. So I had to do what the family wanted to clear my conscience. Now we are doing all the rituals, the Zulu rituals and the family rituals before we will even do anything.

So as a healthcare professional, I know I have been treating these children with hydrocephalous and you can see their progress. But with my child it was unusual because the fluid was not growing. It is there and if you look at my child, he looks normal, but when you talk to him, that is when you realise that there is a problem and that he is hyper active. So when I see a patient with something similar to that, I take my time to really know what could be wrong as it can be something to do with the ancestors like in my child's case (Sr. Andiswa).

As mentioned, nurses' understandings of illnesses are shaped by many factors. Sr. Andiswa, as a well experienced as a professional nurse, although not directly responsible for treating her child when he was ill, said she is able to better decipher illnesses. This ability, she said, comes from acting as a mother and observing what was happening to the child, her nursing training and other clinical experiences with patient. As Tanner (2006: 206) stated, "sound clinical judgement rests to some degree on knowing the patient and his or her typical pattern of responses, as well as an engagement with the patient and his or her concerns". This *knowing* is usually derived from working with the patients and hearing their experiences also known as "life history" in the clinical setting. Thus, the experience Sr. Andiswa had with her child and her knowledge as a nurse contributed greatly to how she notices patterns of illness amongst patients. Tenner (2006: 205) has asserted that:

> Clinical judgment require various types of knowledge; that which is abstract, generalizable, and applicable… that which grows with experience where scientific abstractions are filled out in practice… aids instant recognition of clinical states; and that which is highly localized and individualized, drawn from knowing the individual patient and shared human understanding.

> *There was this child who was presented with pneumonia and was treated for it but nothing happened, then we commenced treatment for pulmonary TB for six months and the patient was discharged. Then after a short while he was brought back for the same issues he had earlier. Then the aunt who was staying with him said she also had the same problem. That she has been treated for pneumonia and for TB but nothing has improved. They were not even diagnosed as having TB from the chest X-Ray. Just that it is pneumonia that is not responding to any antibiotics that was why we tried the TB treatment. The condition subsided for two to three months then they came back again. I suspected that something else must be wrong her. So I spoke to the aunt and that was when she told me that she thinks it is some idliso (food poison) that had been put in her food which she ate with the child (Sr. Andiswa).*

This narrative shows an incident Sr. Andiswa had with a patient in the hospital whom she thought had TB, but later realised he was suffering from an illness related to "traditional" poisoning. With 12 years of experience as a senior nurse Sr. Andiswa showed confidence in how she is able to decipher patterns of illnesses suffered by patients. Aside from her nursing training, the experience she had with her child, her belief in the cultural influence of ancestors on humans also contributed to how she is able to "identify" and group the illnesses suffered by patients. As research has shown (see Benner 2004; Benner, Tanner and Chesla 1996; Peden-McAlpine and Clark 2002; Tanner 2006: 2050), clinical judgment can be greatly influenced by the personal experience and exposure of the nurses than just the "objective" data of the situation. In the second story of the suspected TB patient, her suspicion of the patient's illness was solidified by the patient's aunt who told Sr. Andiswa that the patient had eaten some *idliso.* This shows that sometimes the nurses depend on the life history of the patient either from the patients or from their relatives.

> *When a person comes to the hospital, initially the person may be seeking for help as offered in the hospital. But as a traditional healer as well as a nurse, I will try to find out more history from the person. Firstly, I will treat them medically. While I am treating them medically I will try to find out from the person his or her personal history and all that. I will try and link what could be the cause. Because mostly, people come to the hospital thinking that they are sick. Mostly the patient might be fitting at night and all that and they will think that the patient is having epilepsy and all that. Meanwhile, his or her ancestors are trying to communicate with him or her. So the patient will be having server headache and fits all because the ancestors are trying to communicate with him or her. So I as a traditional healer, I know all the signs when a person is being visited by their ancestors and he is not sick. It is just that he needs to accommodate his ancestors through some rituals and other rites. So we will give the person the medication here in the hospital, we do x-rays and we do all the test but we will find that the person is NAD, which means no abnormalities detected because she is not sick, but she has this problem and maybe she knows but does not want to admit. So in that situation, I need like a special place to sit down and talk to him or her explaining what is happening. Sometimes the patient knows that problem but she or he will try to*

run away from it. Especially this people who say they are "born again"; they really run away from their tradition. Most of the time that is the case. But sometimes the person doesn't know, and then I will make them aware. She [sic] (the patient) will go home and do all those procedures I would have told her [sic] to do and sometimes she [sic] will ask me to perform for her and she [sic] will come back and thank me, saying 'you have saved my life' (Sr. Nelisiwe).

While Sr. Andiswa mainly depended on her professional 'know how' *and* her cultural knowledge of illnesses, Sr. Nelisiwe seems to have in the first instance, a more culturally rooted ability to decipher what illness a patient may be suffering from. Being a cultural healer, gifted as an *isangoma* and an *inyanga*, coupled with her 23 years of experience as a senior nurse, she said she is able to see beyond what the patients even know about their illness. In line with Sr. Nelisiwe's belief, Cioffi (2000) stated that "the experienced nurse encountering a familiar situation, the needed knowledge is readily solicited; the nurse is able to respond intuitively, based on an immediate clinical grasp and just 'knowing what to do'". McCarthy (2003b) in her study showed how profound the influence of nurses' knowledge and experience was towards clinical judgement. She showed how a variation in nurses' ability to decipher patients' illness was based on how knowledgeable and experienced each nurse is. This notion of clinical thinking and judgment is strongly based on Hammon's (1981) Cognitive Continuum theory.[29] As the theory states, each nurse possesses a level of intuition based on her level of exposure and experience with similar patterns of illness.[30] The most experienced nurses are able to immediately identify, without much difficulty, a pattern of

[29] This is a "descriptive theory that illustrates how judgment situations or tasks relate to cognition" (Standing 2008: 124). The Cognitive Continuum Theory places focus on judgment and decision-making. Although the theory was originally initiated for use within the scope of cognitive psychology, it has proven to be of good use within clinical nursing settings. As Standing (2008: 125) states, the theory "offers researchers of judgment and decision-making a framework in which the concepts of task and cognition are linked together". Thus, it gives nurses a framework in which to be guided in understanding and analysing the decisions they carry out within clinical situations as it helps them to enhance understanding, accuracy and effectiveness in clinical judgment (Cader, Campbell and Watson 2005: 398; Harbison 2001: 126; Lamond and Thompson 2000: 211; Thompson, Cullum, McCaughan, Sheldon, and Raynor 2004: 68).

[30] The use of intuition in nursing has been discussed extensively by many writers (see Benner *et al* 1996; Schraeder and Fischer 1987; Leners 1993; Tenner 2006: 206-207). In most of these studies, intuition is regarded as the prompt apprehension of any clinical situation that nurses would have had similar experiences of.

illness that they have encountered over the years, while the less experienced nurses depend mainly on theoretical interpretations.

> *...we have also had situations whereby after all sorts of tests and scans had been done, were were not able to detect what is wrong with the patient... like we had that patient who had a swollen face and neck.*[31] *Many tests were done such as TB, lumber puncture, blood tests and it did not bring out anything that could be linked to the symptoms the patient presented. So I was aware that it could have been some muti that had been used on the person and there is nothing that can be done medically for him and the patient ended up dying in the end. Even the family was aware that it was muti and they wanted to take him to the traditional healer. Unfortunately it was too late (Sir Jabulani).*

Sir Jabulani was convinced of the patient's condition as being bewitched using *muti* based on his experience of similar incidences in his community. He said he was told by the patient's family that the patient had just been promoted at work, and because of the "*jealousy that is amongst the* Zulus[sic]*, someone must have used traditional medicine to attack him",* he said.

Aside from participants like Sr. Andiswa, Sr. Nelisiwe and Sir Jabulani who had a strong conviction in their ability to decipher when a person had an illness linked to one cultural practice or the other, other participants seemed unsure on how to decipher patients' illnesses.

> *We do have some patients although, that after all kinds of tests we still do not know what is wrong with them, or it might be wrong diagnosis. There is one in my department presently, we did everything and we found a certain condition and have been treating her for that condition, normally she should be getting better but she is not. Instead, she is getting worse day by day. So now I wonder if we got the right diagnose or maybe something else might be involve in this (Sir Siyanda).*

[31] This is the same patient referred to in 3.2.2

Here it will be seen that Sir Siyanda was unsure if the patient's state of health was due to some cultural practice or due to misdiagnosis, thus being unable to treat the patients' illness. Another participant also referred to the possibility of misdiagnosis and the discovery of "traditional" herbs in the patient's system as how they can notice or group what a patient is going through.

> *It is rare to find all tests NAD because there are so many tests and surely a person will be found with one thing or the other. X-ray, urine and electrolytes, FBC (full blood count) to detect the HB haemoglobin as well as the platelets of the patient, thrombocytes, INR (International Normalised Ratio), BSR, surely there will be one thing found. Even when a person is presenting different symptoms from what we diagnosed them with, it could be that the person has been misdiagnosed. Sometimes they end up taking "traditional" herbs that they have been given by the healer and we are able to know from the black or greenish watery stool that the patients release. They are usually given that in a drink or enema by family members when they visit them.*
>
> *Mostly, all those that take isihlambezo have adverse effects. You only see that a person has taken isihlambezo from the effects and when you ask they will tell you yes I took isihlambezo (Sr. Phindile).*

The patterns of illnesses narrated by the nurses are either illnesses that seem not to have any cure within the hospital or an illness where the patients have "consulted" a "traditional" healer. Although the nurses where technically trained in specific approach to all illness presented in the hospital, the nurses took decisions that would be considered not in line with the hospital's practices, yet to their satisfaction, were for the goal of promoting the patients' health. As Tanner (2006: 205) asserted, "clinical judgement requires a flexible and nuanced ability to recognize salient aspects of an indefinable clinical situation, interpret their meanings, and respond appropriately. In this case, the interpretations of some of the illnesses were not only based on the nurses' biomedical training and clinical experience, but also on their cultural understandings of illness and clinical "critical thinking"[32] supported by their biomedical tests results.

[32] Critical thinking within the clinical environment has been defined by Facione (1990: 315) as "purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as the

5.3 Nurses' Understanding of Patients' Response to Hospital Treatment

…we have patients here that their parents feel they want to take them away. Just like the patients whose file is in front of me now, his parents brought him here and he was diagnosed with diarrhoea and dehydration and we were still treating diarrhoea when we found out that the child also has dysentery with blood in the stool. On the same day when we got the results of the dysentery the parents came asking to take the child home. We advised them not to take the child as the child was still sick. We tried to explain to them, but they said the grandmother of this child wants to remove inyoni. They said the child is not sick; that it was inyoini (meaning the person was stroke by a bird –inyoni). We asked them to just wait for the treatment before leaving and they can even sign RHT (Refusal of Hospital Treatment form) and go home but continue with the medication or do whatever they want to do afterwards. But while we were busy with Doctor's rounds, they ran away with the child. We phoned them and begged them to come and just take the medicine because we were worried about the child. They said they were coming. We waited and until today they never came (Sr. Anele).

They will come here and say you are not helping my brother so I am here to take him. For those things we cannot stop them. They have to sign the person out. Most of the times it is either the person dies or they come back in a worse condition because there they will be given enemas, they will be incised, they will be caused a lot of infections then they will come back here dying (Sr. Nothando).

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explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment was based". This definition is also in line with Salsalli, Tajvidi, and Ghiyasvandian' (2013: 172) definition of critical thinking as and evidential practice with the hospital using methodological approaches to patients.

We also have situations where patients or their family members say they will want to take the patient to the traditional healer for help because the person has been bewitched. One of such situations I had here was when a patient was having fits, and her family members came and said they want to take her away to an inyanga. When I asked him why, he said that is the only person to help the sister. So such shows that people have different beliefs and what they think will work for them (Sir Siyanda).

Here we see narratives of how nurses said patients were sometimes taken away from the hospital by their relatives. However, I focused more on how the nurses react to the patients' actions. The nurses' reactions show how much their cultural understandings also contribute to how they react to other people's clinical behaviours. The nurses' cultural understanding of illness either made them to easily wave off any attachment to cultural practices by patients in the hospital or acted against such. Telling me about the child whose parents took him away, Sr. Andiswa seemed sad that parents sometimes mistake what she referred to as "*normal*" illnesses associated with children, (like flu and cough *etc*. in her understanding) for illnesses that are related to their cultural practices. She said she had seen many of such cases in the children's ward where she was situated. Sir Siyanda also shared how patients are taken away, either by their choice, or by their family members' decision. He said sometimes the patients asked for a "pass out", claiming they need to attend a family ceremony, whereas, they are trying to simply leave the hospital for a traditional healer.

…there was a middle aged woman who was diabetic and I was supposed to give her antibiotics and injection. She passed out immediately, but before passing out she said "you have just killed me". At that point I didn't know what that meant or why she was saying that because for me I was only trying to help. I thought she was just joking, but when she passed out I got scared. I called for help and the doctors tried to resuscitate her. I was so scared that she was going to die knowing that she said I was killing her just after injecting her. Being that it was almost the end of my duty, I had to go. When I came back the following day, I went straight to where she was and there she was sitting. I looked at her and saw that she was talking and seems better. So afterwards I went back to her to ask what really happened. She said after I gave her the injection she could feel that something was wrong.

Then we later found out that in her cupboard, there was a bottle with some herbs that she had taken. So using that herbs and the hospital medication almost caused her her life (Sr. Nosipho).

As asserted by Sr. Nosipho and elsewhere by Sir Thabiso, patients try to 'mix the hospital's medications with the medications they would have received from the "traditional" healer or would have been brought to them by their family members. While Sr. Nosipho said she understood why the patients still wanted to make use of their "traditional" medicine, even while in the hospital, she felt that mixing the medication can cause much harm to the patients, as in the case of the patient she mentioned. Many other nurses alluded to the fact that mixing medications even when it is not traditional herbs, and when not prescribed by the right person or properly administered, can be of great harm to patients. The challenge faced by nurses here is, knowing if they should allow the patients to mix the medication or not, whether they should recommend the patients to visit a cultural healer or not, all based on their judgment of the patient's illness and its condition.

Although traditional medicine works, but it is dangerous when you try to mix it with the hospital treatment especially amongst children with diarrhoea. It causes more dehydration and sometimes it delays the treatment of the child (Sir Wandile).

…the baby gets distressed and tired then you ask (the mothers) have you taken any isihlambezo and how much have you taken. Then you find out that the parents believe that when you take it you will get a faster labour than the others. You never find somebody who will say I have taken isihlambezo and all the labour process is normal, there is always an issue. Every time the baby gets tired and distress. …when I was a student, a baby was brought at night. The baby was severely distressed and could not even breathe. He was so distressed. He was placed on oxygen; the abdomen was so descended, they tried putting up the drips, the baby was gasping for oxygen and then treatment was started they drew some blood. The baby came at 7 by 9 the baby died. After that we started asking what happened. Then the granny came and said that she suspected that the baby was catching flu, so she gave traditional enema to the baby. But that made the baby more sick and even died. So from then, I was so careful. Even at

home I used to tell my sisters and brothers please do not give enema to your babies because I saw something very terrible (Sr. Phindile).

I am not sure if traditional medicine works and we are not sure of the strength of the traditional medicine they use because some of it can cause renal failure and affect the kidneys too. They usually go into renal failure which is difficult to treat. That is why we discourage them from using traditional medication. We had one case whereby a patient was given traditional medication by relatives; it was the patient's daughter. …they called us when the patient started vomiting and coughing out stuffs then the patient died in a short space of time. We told the lady that look, your mother was sick, but she is now dead and we do not know what the cause is but we have been told that you gave her some herbs. So you see, I surely cannot allow someone to take those things when we do not know what implication that might have (Sr. Sindiswa).

These narratives show how some nurses agreed with the doctors' expectations of them in order to avoid any medical complications, thus, revealing the influence of biomedicine on them. In the narratives, we are presented with critical realities whereby nurses curtailed how much they support any form of cultural medication due to the accidents (sometimes morbidity) they said were potentially caused by the use of cultural medications. Although some patients may have attempted combining herbal and Western medication at the same time, nurses frowned at such practice due to the possible complications that may arise as *"some traditional medicines are good while some are bad because their effects can actually cause more harm to the patients"* (Sir Thabiso). This avoidance show that nurses, as Tanner (2006: 207) asserted, "use a variety of reasoning patterns alone or in combination; and the pattern evoked depends on the nurses' initial grasp of the situation, the demands of the situation, and the goals of the practice". The nurses' priority in the above narratives is to work towards enhancing patients' health, but mainly within the scope of biomedicine.

5.4 Nurses' View on Why Patients Handle Their Illnesses As They Do

> *It is just that their beliefs and their minds have been set that they are traditional people and if they do not receive that traditional treatment they will not be well because they belief that that is who they are. Because there are different beliefs such as the traditional and religious, some beliefs like that of the Jehovah Witnesses who do not accept blood, if you get a patient from such a church even when he is pale and needs blood transfusion, but because he or she beliefs that he or she should not be transfused blood from someone else, he will not accept it. And because we respect their beliefs, we do not transfuse even when we see that the patient needs it… We could have helped such a person, but because of their beliefs and we are restricted not to go over their beliefs (Sir Jabulani).*

> *It is because according to our understanding as Zulus*[sic], *there are those illnesses that people believe that can be treated in the hospital, but this another is considered as a Zulu thing or patients may believe that they have been bewitched and it needs a traditional healer not the Western medication and that Western medication cannot help it. So when they come to the hospital, they would have thought that they can be helped here, but if they are not getting better they will say no it is a Zulu thing and we need to go (Sir Thabiso).*

> *But I think what makes some families to take their relatives our or bring in some medication is that they might have done some consultations while the patient is in the hospital and would have been told certain things by the isangoma and have been given the muti to use and I do understand them (Sr. Nosipho).*

The use and belief in "traditional" medicine and practice has continued to persist in many African countries despite the expectations that came with the advent of the so called "civilization" and its medication. A people's practice reveal how they live their lives and their adherence or (non-adherence) to any practice they regard as foreign (Ashforth 2000; Niehaus 2003: 185). The nurses' belief in cultural practices and constructions shape how they

understand patients' dilemma of choosing one treatment system over the other and if the patient should be allowed to act as they do or not. As stated by Sir Jabulani, the patients have *"their beliefs and their minds have been set that they are traditional people and if they do not receive that traditional treatment they will not be well because they believe that that is who they are".* As such, some treatments are deemed unsuitable for certain illnesses by those who have a strong belief in "traditional" medicine and practices.

Aside from the personal belief and adherence to "traditional" medicine being the cause of patients leaving the hospital, there were also issues of distrust of biomedicine and its personnel as raised by the research participants.

> *Maybe they criticise us and they suggest that we are not happy about one two three. Then they suggest what they want to see being done. When they offer the suggestion box, you find out that they are suggesting something and saying instead of this, I prefer you do this and this, saying they are happy with this or that (Sr. Khanyisile).*

> *So those who want to go to traditional healers even when they are in the hospital it is because of lack of knowledge, their beliefs, or culture. Some of them do not trust nurses and doctors. They believe that they have izangoma and the izangoma will help them (Sir Siyanda).*

Sometimes due to a people's belief that certain illnesses can and should only be treated "traditionally", patients dismissed the use of the hospital's medication due to their lack of trust in the medicine or the personnel. Thus, as stated by Janzen (1978: 15), they believe that "allopathic practitioners[33] cannot treat them", thus leading to some form of scepticism towards allopathic medicine and its practitioners. Golooba-Mutebi and Tollman (2007: 72) stated that in such sceptical moments, "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". More so,

[33] Allopathic Medicine is a broad term for medical (biomedical) practice, also known as Western medicine, *"modern"* medicine or "*'evidence-based'* medicine. The term "allopathy was coined in 1810 by a German Physician, Samuel Hahnemann to refer to the usual practice of medicine as opposed to homeopathy, the therapeutic system formed by him. Homeopathy "is based on the concept that disease can be treated with minute doses of drugs thought capable of producing the same symptoms in healthy people as the disease itself" (MedicineNet.com 2014).

Scheper-Hughes (1992: 42) in her study, "The Violence of Everyday Life in Brazil" stated that "when allopathic therapists are not reassuring, people look to traditional practitioners for treatment and explanations that lessen fear and anxiety". As seen in Naidu's (2012) study of cancer patients in a Durban hospital, most of the research participants were unhappy with how the approaches used by the healthcare workers seemed to ignore other aspects of their humanity and only focus on the sickness. Naidu (2012: 77) stated, "…many of them (the cancer patients who were the participants for her study) mentioned that the doctors seemed to treat the cancer ant not the patients (Naidu 2012: 77). Although cancer and its understanding is not culturally peculiar to only *isi*Zulu-speaking people or their nurses, the study shows how patients sometimes deride the approaches used by biomedicine. Hence, "although bio-medical approaches are recognised and even understood" as stated by Gumede (2009: 55), "they may still be regarded with suspicion".

However, another nurse stated how some patients view all illness as culturally caused.

> *Some of such people still come to the hospital even when they know that they will want to go to an inyanga just for us to stabilise the child and then take the child to the traditional healer. When they are here, they never want to stay for more than four day for them to go somewhere else. Especially with the mothers, they have pressure from the families that they have to take this child to the traditional healers. Just like the 12 years old child[34] who was admitted here with TB and meningitis. Even though the explanation was given that this child had meningitis, the family still believed that it was not meningitis that he was bewitched because he was cleaver at school, the family was doing well and so someone was against them. They also interpret stroke as isilonda, meningitis, when a child has collapse it is called isilonda. When a child is weak and not playing, they call it isilonda (Sr. Andiswa).*

[34]Also referred to in 3.2.2.

5.5 How Nurses React To Patients' Illnesses

> *So when I notice that a person is suffering from something other than what the hospital thinks he or she is suffering from, I need to intervene. I will go to her, make a special prayer, but I cannot burn my imphempo, the incense we burn because we are in the hospital. But since I am gifted as an isangoma and an inyanga, then I can pray and talk to God or talk to her ancestors at the same time then they will show me what is wrong with the person. Like even if a person is hiding something from me I can know that you are hiding something from me (Sr. Nelisiwe).*

Being an *isangoma,* Sr. Nelisiwe is able to view, understand and react to patients' illnesses in other ways than many other nurses. The hospital authority is aware that she is an *isangoma,* and she shared that they respected that and even called on her services sometimes. She said she was called to attend to a nurse who seemed hysterical, but after she spoke to the nurse's ancestors, they communicated to her that something was wrong with the nurse's child at home. Although Sr. Nelisiwe felt confident in being an *isangoma* and a nurse, she cannot openly carry out her cultural practice within the hospital except when called to do so. She said she still respects the fact that the hospital will prefer to treat patients with the hospital's medication and in the hospital's ways only.

Unlike Sr. Nelisiwe who although could not carry out all her cultural practices in the hospital but still enjoyed some level of freedom, other participants felt they have to hide whenever they want to suggest any form of treatment to patients aside from the hospital's treatment.

> *When we did our nursing studies, we were told that we must never introduce traditional medicine to our patients, so I cannot do that. Even when I see that a patient really needs it, I am forbidden by the South African Nursing Council rules. I may tell the person, can I see you later on, then I give them my number so that automatically it becomes a private talk. It will not be a hospital kind of thing. So no one can say to me the person was in the hospital then I told them to leave the hospital and come and see me (Sr. Thabile).*

Despite also being an *isangoma* and known by the hospital as Sr. Nelisiwe, Sr. Thabile stressed how she does all she can to abide by the regulations that prevents her from introducing any non-biomedical treatment to patients.

> *Because I am concerned about the health of the patient and being a Zulu person, I know that some traditional medicine helps and some don't help. But that doesn't mean that the traditional medicine doesn't work, it does work. So there were times when I see that medically we cannot help a person, I ask them to maybe go and see someone who can help them. We make sure that we do not allow them to mix traditional medication and that of the hospital; it does not work together (Sir Jabulani).*
>
> *If I am to meet something like that here in the hospital (Referring to the case of her child, which has been cited earlier in 3.2.3), I will make sure we first do all the tests to check if there is something wrong and if it comes back to say there is nothing, sometimes I will say rather check on the side of your culture. Maybe something needs to be done. Although the hospital will not be happy if we allow the patients, but we as nurses, we are in close contact with the patients, we talk a lot and in that way we are able to relate more and know more on what should be done. So we can talk to them as a nurse and a patient, but afterwards she will come to me at the side and say "sister, I understand what you told me, but now, let us look at this thing in the reality of our culture". Then that is when I open up to her and say if you see that it is something that needs you to carry out some rituals, then I will advise you to go on with that. I have to do that though not in front of the hospital management because I think there reaction will not be positive to what I have said to the patient. So what I advise patients to do is to use one thing at a time and not mix it. Being a Zulu person, I know that Zulu medicine works and when a person insist on using it even when they are suffering from what we can treat, I do not really fuss (Sr. Nosipho).*
>
> *What I normally do is to say, "okay, maybe something is wrong between you and your ancestors, so go to an isangoma and find out what is wrong with you"... I do suggest and sometimes even while we are treating the child, a person can go and consult the isangoma. If it is something that can be done, let*

it be done, because sometimes you do not even have to give herbal medication. Sometimes you just have to slaughter a goat at home and the illness will be gone. The incident with my child was an eye opener in this and I do not just take things for granted. So I do suggest that. But even if I will say it I will make sure I don't do it in from of any senior member of the hospital board (Sr. Thabile).

While Srs. Nelisiwe, Thabile, Nosipho and Sir Jabulani felt confident to when they can suggest to patients other forms of treatment aside from the hospital treatment, other participants strongly felt that it will depend on the sickness the patient is suffering from.

…so it depends on what illness or circumstances the person is suffering from. While for some I will not hesitate to suggest to the patients to go see an isangoma especially when the patients have been told by the traditional healer that the ancestors are not happy with him or her because he or she failed to perform a certain ceremony, they can suffer for it. So, because we are also Zulus[sic] *and we are cultural, we might as well advise them to go for the traditional help when we are not able to help them here. But for some illnesses, I know that they can and should be treated biomedically (Sir Jabulani).*

Although I belief that a person can be bewitched, but sometimes when people take traditional medicine which seem to be boosters, they tend to boost their immune system and they appear to be HIV negative and they will think that they have been cured by the traditional medicine… I am a Zulu guy and at home I have to leave my profession and do what my family does because that is our tradition. But sometimes it is not safe. Like a traditional healer may use razor blades in cutting a person's wound trying to heal them, but then they do not sterilize them and that is very dangerous. So I will not like to tell someone to go for that. But when the person just wants to consult and they will not have to use any blades or herbs on them, then I do not mind. So in the end it will depend on what type of illness the person is suffering from and where I meet the person (Sir Siyanda).

I am not allowed to and cannot judge and I cannot say what you should do. I can only direct them. That is why I had earlier said it depends on what illness. Like I have a file then I see that they are HIV positive, and then I will direct them in a way that they will take their treatment even when they feel they need traditional medicine to supplement. But I also do not want to invade in their thinking that they have been cursed or what. So it depends on the illness. Although the hospital will allow me to recommend in whatever condition because it treats patients in the Western way, when I think it is necessary, I will do it. And it is not easy to do that knowing that we are in the hospital. Say in this case of the patient who tried to commit suicide and with other patients who might be HIV positive, do you think that there is any way that the hospital can accommodate their beliefs and traditional practices? So whatever I will say to the person will depend on the type of illness (Sr. Nontokozo).

These narratives portray some of the dilemma faced by nurses in carrying out clinical decisions. While some felt they should never recommend a patient to seek any form of cultural help, others seem to suggest that they should be allowed to do so. Not only that, they felt they should be allowed to do so, they find themselves in situations whereby they feel they have to do so based on their cultural understanding of the patients' illnesses. However, as stated by participants such as Sir Siyanda and Sr. Andiswa, they do so at their own peril because if they are caught, they stand the chance of losing their jobs. The difficulty in deciding what to do in such situations can be said to exist due to the "imagined" and sometimes real disparities that exists between the *isi*Zulu-speaking nurses' understanding of illness and the expected biomedical understanding of illnesses. Within the biomedical approach to illness, cultural factors are given little or no room in understanding and treating patients' illnesses. However, as stated by Kleinman and Benson (2006: 1673), "cultural factors are imperative to diagnosis, treatment, and patient care" as they contribute in shaping nurses' health-related beliefs, behaviours and values. As such, nurses, can possibly be caught up:

> …between two worlds: the world of technological medicine, that symbolizes modernism, and the realities of a developing nation whose patients and doctors hold traditional and popular understanding of

> illness that requires simple technologies to alleviate the most prevalent diseases (Finkler 2004: 2048).

Thus, "an understanding of not only the pathophysiological and diagnostic aspect of a patient's clinical presentations and disease, but also the illness experience of both the patient and family and their physical, social…" (Tenner 2006: 2005), needs are to be taken into consideration in order to assist nurses carry out "good" clinical judgment. In doing such, the nurse will become more and more a "critical thinker". Although Tenner referred to this statement based on a research in an Intensive Care Unit and its patient care, it also fits into how nurses carry out clinical judgments in any clinical situation and especially in South Africa where there are many factors at play in people's health and health beliefs.

5.6 Conclusion

In this chapter I explored how nurses' understanding of illnesses and health shape their approach to patients within the hospital. In order to do this, I looked at narratives and personal experiences shared by nurses within and outside the hospital while embarking on clinical judgments. Carrying out clinical judgment, as stated in the chapter, involves the use of "critical thinking". Exploring how nurses notice and group patient's illness, the chapter showed how nurses not only rely, on their (important) biomedical training in deciphering illnesses suffered by patients, but also on their wealth of experience in nursing and on their cultural beliefs and understandings of illness. This ability to decipher is what makes the nurse a "critical thinker", says Facione (1990: 315).

The chapter showed that the nurses in this study had a general belief that illnesses are treatable by both cultural and allopathic therapy. However, some illnesses, they believed can be treated by both means while some are caused and can only be treated in the cultural manner. The decision on which approach to use depends on whether the nurse is at the hospital or at home. Golooba-Mutebi and Tollman (2007: 73) asserted that despite the choice of approach, "one approach may be preferred because of the entranced beliefs about its relative efficacy or suitability" to the patient as decided by the nurse.

CHAPTER SIX

Concluding Summary

6.1 Introduction

Embedded beliefs and practices have an impact on people. The Zulu cultural tradition and the "tradition" of biomedicine can both be, in a sense, counted as embedded belief systems and practices. Biomedicine, over the years, has however, been implemented in a hegemonic manner that tends to make it appear superior over non-biomedical systems of health (see Chigona, Glen, Stam, Stam, Van Belle and Wu 2008: 2; King 2006: 13; Mngqundaniso and Peltzer 2008: 382-383; Ross 2007: 16). The *isi*Zulu-speaking nurses in this study, were biomedical personnel, having been trained in the ways that biomedicine views health and illness. As such, they were also expected to view health and illness as they have been taught and carry out clinical decisions in the same manner. Cultural traditions, however, play a strong role in people's worldviews. Thus, despite the training received by the *isi*Zulu-speaking nurses, their cultural understanding of health and illness cannot be separated from them. It also contributes to shaping how they view health and illness, and in their daily clinical decision making. This chapter presents the findings, analysis and understandings of the study. I also present recommendations and observations learned in the course of the study.

6.2 Review of Literature

It can be arguably stated that, the South African health system has seen different faces over the years. The changes in the health system, some may argue, is negative as it may have eroded some of the local customs and practices in relation to health. While the introduction of biomedicine in South Africa is thought to have brought the promise of a "better" health system in light of the "modernisation", there has also been as the narratives show, reluctance in accepting this Western practice in its entirety. As such, there have been agitations for the promotion and inclusion of "traditional" form of medicine and medication in patient care within the country (see Chigona *et al.* 2008: 4; King 2006: 13; Mngqundaniso and Peltzer

2008: 383; Richter 2003: 3; Ross 2007: 15). This agitation was motivated by the observation that "many Western health-care practitioners tended to adopt a cynical and sceptical stance in relation to traditional medical systems, labelling them as unscientific, unreliable, and even dangerous in some instances" (Ross 2007: 16). This scepticism has continued to exist despite the visible role played by traditional medicine in the country's public health care. These downplay of the role of "traditional" medicine and the beliefs surrounding it began to drastically change due to the "global resurgence of interest" in the so traditional health practices and traditional medicines. Chigona *et al.* (2008: 2-3) for example, asserted that

> …some Western practitioners do acknowledge that there *may* be psychological value and benefits conferred by traditional healing methods" and that "a number of traditionally prescribed herbal treatments have demonstrated beneficial physiological effects on a number of specific diseases – sometimes leading to the development of proprietary medication by Western drug companies.

In 2003, for example, it was shown in a study conducted by WHO that over 80% of the world's population made use of traditional medicine for their primary health care (WHO 2003). During the same year, there was also an estimate of the annual purchases of natural products. The study revealed that in Canada, the purchase exceeded $4.5 billion and $60 billion in the international market (Aitken 2003). Most of the natural products referred to in these studies are derived from what is known as the indigenous knowledge of plants, leaves, roods and herbs in general. According to Chigona *et al.* (2008: 1) about 60 to 80 per cent of South Africans make use of traditional medicine. These statistics represent the general attitude of people towards traditional medicine, and shows peoples' attitude towards such medication.

Research is crucial to creating awareness about a phenomenon, garnering support for the idea or educating the public about such phenomena. Much research (see Brown *et al.* 2005: 11; Capra 1982: 336; Dubos 1959: 3; Hahn 1995: 22; Macleod and Lewis 1988: 2; World Health Organization 1983: 126; Stauss 2000: 11) have been conducted on biomedicine and health and how the practice of biomedicine relates or is practiced in societies. Some of these researches (see Capra 1982: 346; Finkler 2004: 2048) show that the practice of biomedicine has remained consistent with its normative understanding and approach to health and illness.

In this understanding, illnesses are only viewed as phenomena of the body caused by the introduction of bacteria that may lead to the dysfunction of one part of the human body or the other. Thus, writers such as Kale (1995: 1183-1184) have written about how culture and biomedicine have remained parallel within South Africa with the two often seen as opposing rather than complementing each other. This is the case because, as asserted by Capra (1982: 336), biomedicine approaches health and illness from a different perspective as understood within local cultures such as that of the *isi*Zulu-speaking nurses. Thus, researchers such as Wedel (2009: 49) wrote about "bridging the gap between Western and Indigenous Medicine…" showing the lapses in the practice of biomedicine and its cooperation with traditional medicine.

Some research has also been conducted on the understanding of illness stemming from the local culturally embedded beliefs that all illnesses have had some form of supernatural power causing them (Gumede 2009: 54; Kirsten *et al.* 2009: 4; Naidu and Ngqila 2013: 128; Setswe 1999: 56; Wilkinson *et al.* 1999: 840). Thus, for a person to be sick, research has shown that the *ama*Zulu believe that there are forces behind the illnesses which in turn can only be healed through the cultural process known to them or as communicated to the *isangoma* by the patient's ancestors. This cultural understanding of illness by the *ama*Zulu has and still has a powerful influence on how *isi*Zulu-speaking nurses understand health and illness. However, this influence of the Zulu cultural understanding of health and illness on *isi*Zulu-speaking nurses in patient care is one of such phenomenon that has been relatively less researched. This aspect has received less attention from scholars, researchers and the South African health and governmental organizations. As Kleinman and Benson (2006: 1673) asserted, cultural factors are of great value to diagnosis, treatment and patient care. They do not only contribute to the treatment of patients, but the health-related beliefs entrenched within cultures can have a great influence on how people also view health and illnesses. As such, understanding how health care practitioners explain aetiology can reveal how their cultural constructions of health and illness are blended in such understandings (Finkler 2004: 2037). This influence and its impact on nurses' clinical decisions and patient care is one aspect that has been least researched.

The nurses' cultural understandings of health and illness may force them to have a certain conception of health and illness even within the hospital. However, due to the hegemonic approach of biomedicine to health and illness, the *isi*Zulu-speaking nurses in the study said they did not feel free to express or show their cultural understanding of health within the hospital space. As such, there could be potential conflict within the nurses.

Despite the formal recognition of traditional healers and traditional medicine by the South African government, the 'recognition' fails to protect it, especially from a potentially oppressive biomedical regime. This initial assertion was later corroborated during the course of my ethnography with statements by the research participants such as:

> *I understand that the government has said we can freely carry out our practice and has a body for us, but do they really trust us or they are just saying they are allowing us because of the pressure on them? I really feel they still think 'eish, these izangoma, we hope they will not give people poisen' (Sr. Nelisiwe).*

> *...yes traditional medicine and healing is recognized by the government. So my problem is not with the government. These [biomedical] training we receive doesn't recognize some of the things we know about illness in the Zulu culture. If I pass through the wards and can feel that this or that patient is suffering from some serious illness that can be healed by us [izangoma] outside the hospital yet he or she has to be here because he or she thought they can be helped here, it pains me to know that I cannot simply openly tell the patient what is wrong with them or even share it with my superiors. It is really not nice to make us have to hide what we know this way. It is like we are still in apartheid you know.*

Embarking on this study, I had the belief that biomedicine, as stated by Finkler (2004: 2048), is still practiced in many societies in its original approach to health and illness whereby "local" understandings of health and illness are given little recognition in diagnosis and patient care. I also had the assumption that this hegemonic approach to health and illness overlooks the reality that different societies have their explanations to phenomena including health and illness (Vaughn *et al.* 2009: 65).

*Isi*Zulu-speaking nurses may find themselves in critical clinical situations whereby decisions need to be made regarding patients in their care. However, they cannot, even when they are convinced and biomedicine has failed to prove otherwise, suggest any cultural treatment to a patient because they need such. As such, this study sought to understand the extent to which *isi*Zulu-speaking nurses are influenced by their cultural understanding of health and illness in patient care within the hospital noting that health and illness amongst the *ama*Zulu is understood somewhat differently as understood in Western societies (see Bates 1997: 1447; Parle 2003, Quah 2003)

6.3 Critical Review of Findings

In the course of collecting, transcribing and analysing the data from this study, many themes emerged. Three themes stood out, based on the reference made to them by the participants, and their contribution to the scope of this study:

1. The understanding of illnesses and healing amongst nurses
2. *iZangoma* as practicing nurses
3. How patient care is shaped by nurses' understanding of illness

Although these three themes made up the three ethnographic chapters of this study and have been discussed extensively, I endeavour to further critique these themes and the findings on them.

6.3.1 The understanding of illnesses and healing amongst nurses

This theme explicated the issue of how the *isi*Zulu-speaking nurses involved in this study understand illness. The understandings of illness shared by the nurses were mainly on how they have adopted their cultural construction of illnesses and their relatedness to their causal agents. While the nurses had different conceptions of what makes a person ill, such as the environment, bewitchment, or curse from the ancestors, they had similar views to what illness in itself is. Some of such views as shown in Chapter Three are:

…to be sick means that there is a certain part of a person's body that is feeling unwell (Sr. Nothando);

…it means the person's body or system is not functioning in the normal way that it is supposed to be functioning and it could be caused by anything. This can be due to certain circumstances, maybe the weather, maybe allergy (Sr. Phindile).

Illnesses are partly natural because we are in the human body, and if there is something wrong with that body one will get ill. So it can just be the body deciding to go otherwise from its natural state due to maybe old age (Sr. Nontokozo).

The different views and understandings of health and illnesses as shared by *isi*Zulu-speaking nurses in this study have been, or were greatly shaped and influenced by their society and their cultural practices and beliefs. As research (see Creswell 2009:8; Rosaldo 2003: 583) has shown, humans approach the world from a particular mind-set, also known as point of view or worldview. Our worldviews, as Rosaldo (2003: 584) asserted, are a construction, or our continual absorption of what we see, hear, and understand about our societies. Not only that, but also what our society has made us to believe about the world. As such, this theme strongly portrays how cultural beliefs, such as bewitchment and the role of ancestors in people's lives can go a long way in determining how they view the world, and in this case, health and illnesses. With strong beliefs in the interconnectedness of people with their environment and with the dead, the theme also shows us how the nurses agree that with a poor outlook on the environment, and experiencing themselves as being part of the cosmological web; people can end up being ill. The role of the ancestors was also portrayed strongly; on how they contribute to the protection of the living members of their families and in turn expect reverence or acknowledgements in the form of rites and sacrifices. When such rites and sacrifices are not carried out, a family ancestor who is responsible for protecting the family is likely to turn his back on them and therefore leaving them vulnerable to any harm that he would have averted from befalling them.

The nurses also had an understanding that seems to dichotomise the view of illness into "normal" and cultural, with the "normal" being biomedically treatable while the cultural needing the aid of a traditional healer. As Sr. Andiswa alluded, that sometimes they are faced with patients suffering from "normal" illnesses such as flue, headache, or toothaches, yet the

patients may feel that these illnesses have a supernatural cause. In such situations, Golooba-Mutebi Tollman (2007: 65) assert that an African person would ask why must they be the ones suffering from the headache or the flue and not someone else? Such a strong attribution of illness to a certain power was also alluded to by Sr. Mpume when she said that *"even when a person has a headache, it is because there is a blockage in the flow of the supernatural power around us and that affects the person's state of mind which ends up as a migrane".*

6.3.2 Living as an *isangoma* and practicing as a nurse

Kale (1995: 1182) has asserted how there is a strong presence and contribution to the South African primary health care by traditional healers. The strong presence of traditional healers and the great patronage they received is seen in how people consult traditional healers before or after consulting a hospital or clinic.

> *When I listen every day I hear things that I have never known before so I expand every day. The universe is moving, things are moving, time is moving. Each and every plan that the world is projecting towards where the world is getting into. I know exactly what will happen next year because I am aware of the energy shifts. What the weather is saying, what the sun is saying, and what the mood is saying what they say and know exactly how it is going to happen. And I know which energy has been suppressed and I know which one is going to come out (Sr. Mpume).*

Just like Sr. Mpume, other *izangoma* in this study believe that they have a certain power within them that can either make them see (spiritually) of feel what a person is going through. The *isangoma* nurses have views that not only emanated from what they have learned from their culture and society, but also from their entrenchment and experience as traditional healers who have been specially chosen and called by the ancestors to take on the role of the "sacred" amongst other people in the community. Thus, they are well respected and their views towards any phenomenon, especially negative phenomena facing a community, are highly regarded.

The *isangoma* nurses play a very important role in healing within their communities. Their understanding of the Zulu cultural practices and beliefs, the inspiration they receive from the ancestors and their biomedical training makes them more valuable not only to the hospital, but

also to their communities as people are able to have more confidence and trust in them. However, there are also *izangoma* who ostensibly deceive people. Such situations were alluded to by one of the research participants.

> *You know some of us are not that powerful yet they deceive people into thinking that they can do so much when they are actually lying. We had a caeser (caesarean) nurse here who was also an isangoma, we used to here that she gets so many people visiting her at home because she treated almost anything. But we later discovered that she was actually stealing the medicine from the hospital and mixing it with her herbs at home and when she gives people, they get healed thinking that it was just the herbs not knowing that she mixed them with the hospital's medicine (Sr.Thabile).*

Such comments display some level of deception on the side of the nurse. Such deception, said Sr. Thabile, is one of the reasons *izangoma* are being distrusted by the government and other medical personal.

6.3.3 How patient care is shaped by nurses' understanding of illness

Although many African beliefs and practices have been regarded as "fetish" by non-African observers, such beliefs and practices play a vital role in the lives of the people who believe in them. Pietz (1985: 9) for example, stated that "European traders in the fifteenth and sixteenth centuries deemed the socio-religious orders of African societies to be founded on the valuing of trifles and trash, so also they remarked constantly on the fact that they could trade their own trinkets for objects of real value". This assertion portrays the love-hate relationship that existed and still seems to exist between African traditional beliefs and non-African observers. Thus, Pietz (1985: 14) averred that the "discourse of the fetish has always been a critical discourse about the false objective values of a culture from which the speaker is personally distanced". As such, a speaker is not in tune with the reality of those upholding such cultural practices and beliefs. Irrespective of the negative perception that may be constructed towards African cultural beliefs and practices, they have a powerful influence that is not only metaphysical, but can have physical implications and manifestations.

The *isi*Zulu-speaking nurses involved in this study have a belief in the Zulu cultural practices and their effect on people's lives. They also narrated many incidences when they suffered such effects or met with patients with such effects. Their response to their family members or the patients' illnesses were, as seen in the narratives, strongly influenced by their personal beliefs and understanding of health and illness which stems from their cultural beliefs and practices.

Their reactions do not only portray the nurses' conviction of their cultural understanding of illnesses; rather, they also demonstrate their response to the attitude of biomedicine towards cultural understandings of health and illness. Their conviction and their teaching and the expectations of the biomedical code of conduct places them in a 'dicey' position as they are not allowed to carry out or suggest any of their cultural views towards illnesses even when they feel the need to do so.

> *They (the doctors) always think they have to have the answers, that they have the answers (to patients' health conditions). But that is not right from my point of view because when I can see that a person is ill and it may be some cultural thing and the patient's families are also saying that we could see that my daughter or my son is sick, it should be a traditional or a cultural thing, it could actually be a traditional thing. So does the that they have to be the ones to heal the patients even when the patient can be helped using traditional medicine as well, it is not correct. But they (the doctors), undermine us (nurses), especially we the African ("black") nurses because they think we do not really know much (Sr. Nosispho).*

This disagreement with the doctors can also be equated with a disagreement with biomedicine as one of the nurses asserted, *"these their [biomedical] rules are just suffocating me"* (Sr. Mpume). One may view the reactions as being strongly against biomedicine and the doctors whom the nurses view as representatives of biomedicine. One may also view their reaction as a result of the ancient rift between nurses and doctors. Many writers (see Coull 2006: 51; Sweet and Norman 1995: 166; Thompson and Stewart 2007: 139-140) agree that there exists a unhealthy relationship between nurses and doctors. Thompson and Stewart (2007: 139) for instance, state that "while the relationship between nursing and medicine should always be cordial and collaborative, tensions continue to simmer beneath the surface

of an apparently healthy partnership between the two to serve the wider community". They went on to state that "indeed the nurse-doctor relationship has often been characterized as strained, even adversarial as it has been smeared with conflict and professional rivalry". This rivalry, claims Thompson and Stewart (2007: 139), is due to "a real and imagined power imbalance with doctors seen as dominating and coercive". Thus, the doctor-nurse relationship takes the shape of a "dominant-subservient" collaboration. However, I will not only see the rift as originating from a personal hatred between nurses and doctors, but an old defensive position taken by nurses who are recruited into the biomedical sphere and expected to grasp, adapt, belief, and use every understanding to health and illness taught to them in biomedicine without any consideration of their personal or cultural understanding of health and illness.[35]

> *Even though I have been educated and I have changed, I do respect my tradition. So even with this nursing profession, if I have to do some rituals, I do. I know about these traditional things. They happen. Especially if a person says they are seeing things, there are people talking to him and all that, because I am a Zulu person I will understand (Sir Siyanda).*

> *I think biomedicine needs to accommodate people's beliefs because the treatment here is Western. Someone might refuse it because they will feel it is not their own culture and prefer their own traditional medication… So there should be some kind of collaboration because some of the conditions are based on the traditional issues and such conditions cannot be treated here in the hospital (Sir Jabulani).*

These responses by the *isi*Zulu-speaking nurses portray the unhappiness and internal struggle they sometimes go through in times of making clinical decisions. Such a condition may be regarded as unhealthy to the support of the nurses' effectiveness in patient care, thus affecting their delivery of good health services. As Karenga (2002) asserted, "culture must be used as a resource for meeting present challenges and not as mere reference of dates and events".

[35] This study did not probe if doctors had a similar feeling of some conflict as the nurses did. Doctors' six to seven years in biomedical training might have shaped their view towards health and illness more radically than it would have for nurses. This, however, is an assumption to be probed in other studies.

6.3.4 The moral dilemma

Aside from the credibility of the *izangoma* or *isi*Zulu-speaking nurses being in question, the credibility of their knowledge and assertions may also be questioned. These can be mainly questioned from the moral rules or code that guides the nursing profession. By possibly practicing or letting their cultural understandings shape their practice within the hospital, the nurses, as many of them agreed, would be working against the ethical or moral code in which they operate within. However, they also remain as cultural beings with all their embedded cultural practices and beliefs, especially towards health and illness. As such, they face a moral dilemma of either being obedient to their professional code of conduct or their cultural beliefs. A dilemma has been defined as "a choice between equally undesirable alternatives (Loveridge 2000: 18). Morality on the other hand, provides a conventional manner of conduct or standard of evaluation within a group (Fowler and Levine-Ariff 1987). It is thus, based on the moral conduct of nurses that their practices of patient care is being monitored and evaluated. As such, an attempt by *isi*Zulu-speaking nurses or *isangoma* nurses to incorporate their cultural approach to patient care within the hospital becomes "immoral" and unethical.

Nursing, has been described as a "moral enterprise" (Allmark 1992: 17) and "the use of clinical judgement" (Royal College of Nursing 2003: 3), which involves the use of one's knowledge, experience and conscience in taking actions in any clinical setting. This means that the goal of any clinical decision otherwise known as "clinical judgment" taken by a nurse, is not technical, rather, moral in that the activities carried out by the nurses are not important in themselves but important based on how they contribute to the wellbeing of their patients.

The decisions taken by nurses, however, are not only shaped by their educational training, but also by their nursing experience, life experience and personal beliefs. Thus, viewing nursing as a "moral enterprise" and "the use of clinical judgement" indicates that aside from knowing the need for a particular intervention and how it will be delivered, nurses ought to be able to "justify, explain and defend judgements and decisions" (Thompson and Dowiding 2002: 190). It has been asserted by Greipp (1992: 45) that eventhough nurses may give consent to the need for a code; they seem to fail when such a code is to be applied to their daily practice. Such a response to the agreed code, Allmark (1992: 16) said is because some of the daily situations faced by nurses may be regarded as non-ethics-based or pertain to their personal beliefs and practices, which may disregard clinical understandings and procedures.

6.4 Recommendations

The findings of this study and my understanding of how people's understandings of the world are influenced by their beliefs and practices give room for some possible recommendations from my perspective.

a) Use of internal *izangoma*

The *isangoma* nurses in this study portrayed how they are able to notice, interpret, and understand patients' illnesses. These skills, as revealed in the study, have gained through their exposure to the Zulu cultural approach to health, but most importantly, by the special role they play in their communities as "chosen healers" or intercessors between their community members and the ancestors. Noting that their view of illness and healing from a cultural perspective differs from that being understood and followed in the hospital, their presence in the hospital can contribute to creating an approach that is more holistic in meeting the (cultural) needs of patients who visit the hospital.

It has been asserted that medical doctors "try to cure sick bodies so as to produce normal, healthy individuals. Physicians no longer strive to eliminate disease, asking 'what ails you?': instead they seek to restore normalcy, asking 'where does it hurt'" (Bevir 1999: 350). However, the knowledge carried by the *isangoma* nurses can be used in the promotion of patients' care in the formal hospital setting. Their services may be sought in situations where the doctors are unable to understand a patient's perspective or when either the doctor or nursing staff feels that the patient will benefit from the 'cultural counselling' that *isangoma* nurses may be able to offer. As Sr. Nelisiwe one of the *isangoma* nurses asserted, *"I as a traditional healer, I know all the signs when a person is being visited by their ancestors and he is not sick. It is just that he needs to accommodate his ancestors through some rituals and other rites".* At such points, because they are well qualified nurses in the hospital who are also *izangoma*, could be called upon to see if they can interpret and understand what the patient is suffering from, or just as importantly *believes'* he/she is suffering from. From there, the *isangoma* nurses may be asked to assist if they can.

The use of the internal *izangoma's* services is potentially viable because cultural healing rites do not always involve the ingestion of any herbal concoction that may be harmful if taken in conjunction with medicine prescribed by the hospital. Mazama (2010: 7), had alluded to the

notion that amongst African people, "what may appear to be a physical ailment, because of the physical symptoms and illness, often turns out to be a spiritual illness". Thus, adhering to both patients' (and nurses') cultural rites and understanding of health and illness would potentially create the conducive psychological and spiritual state for possible healing. This also communicates to the patients that their background and experiences are legitimate and are being taken seriously.

Ignoring the valuable (non-harmful) contribution that can be offered by *isangoma* nurses and even preventing them from offering any help, may even be considered as a form of 'cultural oppression'. Cultural oppression has been defined as "the universalisation of a dominant group's experience and culture and its establishment as the norm" (Young 1990: 59). To avoid this possibility of cultural oppression or negligence, principles followed by *izangoma* can also benefit the practices in public hospitals in creating a level playing ground with cultural medicine thus promoting the effectiveness of nurses who believe in both practices. According to Kale:

> Firstly, patients must be completely satisfied that they and their symptoms are taken seriously, and that they are given enough time to express their fears. Secondly, the healer studies the patient as a whole and deserves credit for not splitting the body and mind into two entirely separate entities. Thirdly, the healer never considers the patients as an isolated individual but as an integral component of a family and a community; thus, members of the patient's family participate in the treatment process (Kale 1995: 1183).

These roles can be effectively played by the *isangoma* nurses in the hospital. Sometimes patients might suffer from illness that the *isangoma* nurses may recognise and understand how to help the patient but the patients themselves may not even know. As asserted by Sr. Nelisiwe: "…*in that situation, I need like a special place to sit down and talk to him or her explaining what is happening. Sometimes the patient knows that problem but she or he will try to run away from it… I will make them aware".* Because "Western doctors do not make practical attempt to deal with psychological and social aspects of illness therapeutically" (Capra 1982: 348), the *izangoma* nurses can be incorporated into the hospital patient care plan to play this role. Their understanding of cultural patient care can be used in counselling patients, although of course not prescribing *muti* or potentially contraindicated medication.

This can aid in the healing of the patients as they will be more comfortable knowing that they are able to be attended to by a traditional healer, and that their adherence to traditional approaches is taken into consideration in their treatment.[36] As such, biomedical healthcare systems ought "to be aware of the beliefs and practices of traditional healers in relation to health, illness… and ways of restoring well-being" (Ross 2007: 17).

b) Use of referrals

Comments below are revealing;

The doctors do not accommodate any traditional practise and we are expected to do the same, especially if a person has to take herbs. Once you are in the hospital here, you have to take the hospital medication only because we will be able to find what is wrong with the person (Sr. Nolswazi);

And;

When we admit the patients, we see that the relatives are trying to give the patients some medications… We stop them and tell them that here the patient is in our hands and they need to give us a chance to try what we do. And the hospital believes that it has to find the cure for the sickness you know (Sir Thabiso).

Patients are not allowed to bring any of their traditional medicines to the hospital for ethical reasons, which is understandable. Research and statistics (see Chigona *et al.* 1; Mazama 2010: 7; Wedel 2009: 49) show that there is a strong adherence to traditional medicine in South Africa, and patients who visit Bambanini Hospital show similar health seeking behaviours. There are, however, the very real possibilities that different medicines (even different medicines from within the bio-medical sphere) might be contraindicated with each other. However, traditional rites are not necessarily toxic or harmful to the person. From the narratives shared by the nurses, they noted that there were some patients' illnesses that they noticed would have been better treated or only treatable using the cultural approach to healing rites, or prayers *etc.*, which are considered important to health, within the patient's own cultural understanding. However, due to the restriction on referrals to traditional healers, nurses are unable to suggest, or at least openly refer patients for such traditional healing rites,

[36] The *isangoma* nurses would also be able to caution patients against potentially dangerous 'mixing' of medication. Mixing contraindicated medication is also dangerous even within the allopathic system.

thus affecting the patients healing process or recovery to health. This in turn further cements the nurses' conformability in medical decisions. As shown in my research, the inability to refer patients that may be in need of a traditional healer by a nurse, may not be based on her volition, but rather, based on the enforced norms of the hospital that the nurse may not be happy with.

According to a South African study on the relationship between nurses and traditional healers conducted by Mngqundaniso and Peltzer in 2008, it was shown that biomedical personnel are not exactly involved in referrals to traditional healers. This study conducted by Mngqundaniso and Peltzer showed that only 14 per cent of the nurses referred patients to the traditional healers while 55 per cent of the traditional healers referred patients to the hospitals. According to the study, five issues were mainly the cause of the referral to the traditional healers. They are "HIV/AIDS, cancer, bereavement, psychosocial problems and depression. Most did not discuss with a patient, benefits of traditional healing but 71 per cent discussed the possible harmful effects" (Mngqundaniso and Peltzer 2008: 381).

These statistics portray the lack of trust of traditional healers by Western medical practitioners (Chigona *et al.* 2008: 15; Mngqundaniso and Peltzer 2008: 381). Chigona *et al.* (2008: 14-15) for instance, noted that "it is actually illegal for Western health practitioners to refer a patient to a traditional healer". They however, also noted that such referral would greatly improve the relationship between Western health practitioners and traditional healers. Such referral does not necessary mean the patient should stop taking the allopathic medication they are using if it plays a role in their illness, such as a patient with high blood pressure.

According to another South African study conducted by Peltzer in 2001, traditional healers refer patients to the hospital for mainly these conditions: "AIDS, diabetes, asthma, tuberculosis, mental illness, sexually transmitted disease, epilepsy, stroke, bone fracture, high blood pressure and others" (Peltzer 2001: 6). However, ***they*** receive little or no referrals from hospitals. Such a one-sided referral practice has been shown to exist due to the mistrust between traditional healers and biomedical practitioners. This mistrust that exists between both practices, claims Chigona *et al.* (2008: 15), "may be justified in some cases, but there exist traditional healers with legitimate and valuable treatment'.

These studies, and my study shows, that there is a need to, at times, refer patients from either the hospital to traditional healers or from traditional healers to the hospital. Such referrals can take place when there is a level of certainty that the hospital is unable to help the patient attain healing and the nurses or patient are convinced that the illness they suffer from can be better attended to by the traditional healer. The possible role to be played by the traditional healers who are also nurses (as some in the hospital where this study was based were) might only be the recommendations of certain rites and counselling. As when patients have a strong adherence to the Zulu health practices, recommendation of rites or counselling from the *izangoma* can go a long way in contributing to their healing process, both spiritually and physically. An allowance of such a practice can go a long way in easing the clinical decision making process of nurses. Thus, if the hospital is able to identify well trusted and reputable traditional healers within the hospital's vicinity, one can suggest that they can refer the patients to such traditional healers.

c) Educating the public

Not all illnesses are fully curable or even fully understandable from a cultural perspective wholly. Many illnesses have emerged in a so called modern context and there are also diseases of affluence, such as diabetes. Society today suffers from numerous diseases and health challenges that have emanated due to the changing world and some from inexplicable sources. There are thus more contemporary diseases such as HIV/AIDS, cancer, and Ebola. HIV/AIDS for instance, is a disease caused by the development of a virus known as the Human Immune Virus (HIV) in the human body (World Health Organization (WHO) 2012: 1). Its prevalence in the country as at 2002 was estimated to be between 11.4 per cent and 20.1 per cent in the overall population (HSRC 2002, UNAIDS 2002, Hunter 2003: 689). Cancer, which has many types, is another major dread disease in our contemporary society. It has been stated that there were about 7 million global deaths due to cancer in 2001 (Danaei, Vander Hoom, Lopez, Murray and Ezzati 2005: 1784). Ebola virus, which has had a recent sweep across some West African states from March 2014 and has currently caused the deaths of about 3,865 people out of the 8,033 reported cases as at October 5 2014 (Bradford 2014). This disease increases the level of inflammatory cytosis in infected humans or non-human primates, which can lead to "septic shock and multi-organ failure" (Bray and Mahanty 2003: 1613).

Although cultural understandings of health and illnesses is important to any health care in societies, it is also vital that people are alert to fact that some illnesses may be foreign to cultural treatment processes and people need to adhere to the relatively more suitable treatments for such. It was in this light that some of the nurses asserted how they are expected and also agree on the need to discourage patients from mixing traditional herbs and medications with the medications given to them in the hospital or to seek the help of a medical doctor when unsure about any condition they face.

> *We receive patients who sometimes refuse their medication even when their illness has been traced and can be treated here, yet they may still feel that they need to make use of their traditional medicine. Especially those suffering from HIV, we let them know that HIV is not due to any cultural curse or anything like that. So we explain how it is transmitted and how it can be managed (Sir Jabulani).*

> *…if I am to see someone these days who will say that they want to leave the hospital and go to a traditional healer, I do not think I will be okay with it. I will advise them not to because those medications they get there are highly toxic and they do more damage in the body than good. I can only advise them and give them health education to not do it. But at the end of the day it is their choice (Sr. Sibongile).*

> *With my experience I have seen some of the children dying having used the traditional medication. So I always advise them that it is not good for them to use herbal medication because sometimes it is stronger. So they need to be educated on Western medicine because site effects are there, doses are there, contra indications, everything its written. Whereas with our medication, you will not even know what the side effects are, what the contra indications are or whatever (Sr. Zama).*

> *I have seen that the more health education you give to the mother, the less medication they will need. The more you educate them, the less they will come to the hospital for anything. Because sometimes you educate them and when they are saying the child is sick and that, with only health education, the mother will be fine (Sr. Andiswa).*

Not only are nurses told of the need to "educate" the patients and their family members, nurses also seem to have a grasp of why they are told to do such, most of which is to avoid any medical complications. Certain cultural medications are not and should not be used as supplements to the noted treatment for certain illnesses, especially when such an illness is foreign to the cultural healer or medicine. Stacey (1988) for example, states that some Zulu people may refuse the biomedical treatment for tuberculosis because of their idea of illness (which is that it must have been caused by someone via a curse), does not tally with the notion of germs as understood in biomedicine. As such, when faced with such situations, helping the nurses to be able to educate such a patient gives more ease to the nurse and a better understating to the patients. The concept of "patient education" has been defined by Beranova and Sykes (2007: 22) as "a combination of learning experiences influencing behaviour changes, producing changes in knowledge, attitudes and skills needed to maintain and improve 'health' (emphasis mine)". In a research conducted by Kaptein and Wienman (2004), it is shown that despite the need of patients to gain more information from clinicians and nurses, they seem to ask less. Thus, any encounter between the patients and health care workers, they say, ought to be used as a "teachable moment". As Krouse (2001: 748) asserted, "patient education is a mainstay of nursing….".

This education, however, can sometimes become one-sided, whereby nurses and patients are taught biomedicine and its understanding of health and illness without the practice of biomedicine and its practitioners learning about the cultural understanding of the nurses and patients. Thus in this case, to "educate", may simply mean to create a deeper awareness of Western biomedicine to the local patients of the hospital, most of whom come from the Zulu cultural group and have a cultural understanding of illness that also works for them. However, expecting "education" to be a one way affair whereby patients are *taught about* biomedicine without the biomedical personal being taught anything about the patients' understandings of illness. Hence, while nurses and patients are taught about diseases and biomedical approaches to them, biomedicine also needs to take into consideration the local context in which it is operating and the cultural beliefs and practices upheld in such locations. As Vaughn *et al.* (2009: 64) asserted, understanding a society and its practice is crucial to sound health delivery.

6.5 Conclusion

How to avoid diseases, breed successfully, and live to a reasonable age, says Sargent (2005: iii), are questions that have bewildered humankind throughout the course of time. However, because globalisation, as stated by Nustad (2003: 7) is the interaction between a "distinct realms of reality with another part of reality", there is the possibility of misunderstandings in the process of this "interaction". Biomedicine within a non-Western society does not directly correspond to its understanding and approach to health and illness. The location and practice of biomedicine, however, is sometimes regarded as superior to the local, non-Western understandings and approach to health and illness. In this context, Zulu cultural understanding of health and illness is being regarded with distrust by biomedicine and such a view is being passed to biomedical personnel, including *isi*Zulu-speaking nurses. These, nurses, however, have their cultural, non-Western, non-biomedical understandings of health and illness. Ignoring this reality, however, potentially deprives nurses and patients of expressing these beliefs within the hospital space. This in some way gives some form of pseudo power to biomedicine.

According to McDougal (2010: 10), "power is a greater modifier of behaviour than law or public policy; and culture is the centre-point of African people's power. For African people, there is a great power in the ability to draw upon the mosaic of African cultural solutions to solve its problems and achieve its goals" including health. However, from this study, it has been shown that *isi*Zulu-speaking nurses working in Bambanani Hospital are almost forced to assimilate the "cultural monism" promoted through biomedicine without giving them room to incorporate their knowledge of health and illness in their practice. The cultural knowledge embedded within the Zulu cultural understanding of health and illness would have possibly helped the nurses to contribute to the diversity of health approaches in the uniqueness of their cultural character. Thus, without understanding the diversity that can be offered to health practice by the Zulu cultural understanding of health and illnesses, it can be cautiously argued that no system will have the full capacity to make use of the approaches to attain well-being.

The idea of healing in biomedicine which sees healing "as the scientific process of treating disease through 'appropriate' medical, surgical, and chemical interventions" (Chalmers 1996: 3) has thus to be reconsidered. The traditional understanding of healing which is the restoration of "harmony and equilibrium through natural, spiritual, and psychological healing (du Plessis 2003: 105) needs to be given a better consideration if *isi*Zulu-speaking nurses' clinical decision making and patient health care is to be aided.

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APPENDIX 1: UKZN Ethical Clearance Letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

20 May 2014

Mr Gabriel Gyang Darong (213571326)
School of Social Sciences
Howard College Campus

Protocol reference number: HSS/0428/014M
Project title: The cultural construction of illness amongst *isi*Zulu-speaking nurses: Probing nurses' understanding of patient's illness and health in hospitals

Dear Mr Darong,

Full Approval – Expedited Application

In response to your application dated 26 April 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Maheshvari Naidu
cc Academic Leader Research: Professor Sabine Marschall
cc School Administrator: Mr N Memela

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
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Website: www.ukzn.ac.za

APPENDIX 2: Gatekeeper Consent Letter

[redacted]

23 May 2014

Gabriel Gyang Darong
Student No. 213571326

Dear Gabriel,

ETHICS APPROVAL " The cultural construction of illness amongst iSiZulu- Speaking Nurses- probing nurses' understanding of patients illness and health in hospitals".

Thank you for your communication with the Ethics Committee of [redacted] Hospital, [redacted] on the above study. The Ethics Committee hereby approves the Research Study.

On a more practical note, please could you continue to ensure that the relevant Staff are appropriately involved in this Research Study. Please could you also ensure that [redacted] Hospital, [redacted] receives feedback on this Research Study.

Yours Sincerely

[redacted]
Ethics Committee Chair
[redacted]

Cc: [redacted] (Acting CEO- [redacted].

- 1 -

APPENDIX 3.1: Information Form (English)

UNIVERSITY OF KWAZULU-NATAL
SCHOOL OF SOCIAL SCIENCES

Dear Respondent,

Fieldworker: Gabriel Gyang Darong
(0785863009/213571326@stu.ukzn.ac.za)

Supervisor: Dr. Maheshvari Naidu (031-2607657/naiduu@ukzn.ac.za)

Research Office: Ms P Ximba (031-2603587/ximbap@ukzn.ac.za)

I, Gabriel Gyang Darong, an Anthropology Masters student at the University of KwaZulu-Natal wishes to invite you to participate in a research project titled: **The Cultural Construction of Illness amongst *isi*Zulu-speaking Nurses: Probing Nurses' understanding of Patient's illness and Health in Hospitals.** You have been chosen because of your knowledge and experience as an *isi*Zulu Sister/Sir Nurse, your contribution will be vital to this study.

This study is intended to look into how your cultural and traditional upbringing coupled with your training as a nurse shapes your understanding of illness and approach to patient care. Your participation in this project will enable me to understand how the understanding of illnesses in the *isi*Zulu tradition and your training as Sister/Sir Nurse shapes your approach to patient care, especially people suffering from culturally-understood illnesses. This study will contribute to the knowledge on patient care, but particularly from your perspective as a nurse and how your identity and knowledge has shaped patient care. Please note that the hospital authority is aware of this study and of your possible participation, hence your participation in this study is not in any conflict with your duties nor will it endanger you employment.

Your participating in this project is voluntary. You may choose to withdraw from participating at any point or choose not to answer any question that you do not feel comfortable answering. There will be no penalty of any sort if you are to withdraw or choose not to answer any question. The information that will be gathered from this study may be published in academic journals and presented orally; however, your identity will be protected

at all times and will only be made known if you so wish. Unfortunately, I will not be able to afford you any financial benefit for participating in this study. You will be involved in at least two or more one-to-one interviews, depending on your willingness, and each may last for about 45 minutes and a focus group meeting with other participants, which will last for an hour and half. These meetings will be at the conference room or any other location of your choice and comfort within the hospital environment or your home. I hope you will take the time to participate.

If you have any questions or concerns about participating in this study, you may contact me, my supervisor, or the University's research office through the numbers listed above.

Yours Sincerely,
Gabriel Gyang Darong

Investigator's Signature_____ Date _____

APPENDIX 3.2: Information Form (*isi*Zulu)

UNIVERSITY OF KWAZULU-NATAL
SCHOOL OF SOCIAL SCIENCES

Ummangalelwa Dear,

Fieldworker: Gabriel Gyang Darong (0785863009/213571326@stu.ukzn.ac.za)

Supervisor: Dr. Maheshvari Naidu (031-2607657/naiduu@ukzn.ac.za)

Research Office: Ms P Ximba (031-2603587/ximbap@ukzn.ac.za)

Mina, uGabriel Darong Gyang, umfundi Anthropology Masters eNyuvesi yaKwaZulu-Natal efisa ukuba uhlanganyele-project ucwaningo osesikhundleni: I Cultural Ukwakhiwa Kokugula phakathi abahlengikazi abakhuluma *isi*Zulu-abahlengikazi: ukuqonda kumba Abahlengikazi 'yokugula Lesiguli Nempilo ezibhedlela. Wena aye akhethwa ngenxa yolwazi lwakho kanye nesipiliyoni njengoba i Nurse isiZulu Sister / Sir, umnikelo wakho kuyoba elibalulekile kulolu cwaningo.

Lolu cwaningo kuhloswe ukubheka indlela okhuliswe ngayo zamasiko zendabuko sihambisana ukuqeqeshwa wakho njengoba unesi usebenzisa ukuqonda kwakho ukugula yokubhekana ukunakekelwa isiguli. Ukuzibandakanya yakho kule phrojekthi kuzokwenza ngaqonda ngendlela ukuqonda izifo kule isiko *isi*Zulu kanye nokuqeqeshwa wakho njengoba uDade/Sir Nurse usebenzisa ingxoxo ngokukhuluma ukunakekelwa isiguli , ikakhulukazi abantu abaphethwe izifo ngamasiko - kuqondwe. Lolu cwaningo kuzokwenza isandla ulwazi kwi ekunakekelweni isiguli, kodwa ikakhulukazi ngombono wakho njengoba unesi kanye nendlela ubuwena nolwazi uye ezimise ukunakekelwa isiguli. Sicela uqaphele ukuthi igunya esibhedlela uyazi kulolu cwaningo kanye of iqhaza lakho kungenzeka, ngakho iqhaza lakho kule cwaningo akusilo nganoma iyiphi ezingqubuzana nemisebenzi yakho futhi ngeke engozini lomsebenzi.

Iqhaza wakho kule phrojekthi yokuzithandela. Ungakhetha ukuzehlukanisa iqhaza kunoma yiliphi iphuzu noma khetha cha ukuphendula noma yimuphi umbuzo wokuthi ungazizwa ukhululekile ukuphendula. Ngeke kube khona isigwebo lanoma yiluphi uhlobo uma ukuhoxisa noma ukukhetha cha ukuphendula noma yimuphi umbuzo. Ulwazi okuyoba ngayo ukubuthwa kusuka kulolu cwaningo kungenzeka ezinyatheliswa komagazini academic futhi ethula ngomlomo; Nokho, ubuwena izobe avikelwe ngaso sonke isikhathi futhi kuyobe kwenziwe laziwa uma wena kanjalo ufisa. Ngeshwa, mina ngeke ngikwazi ukuthenga kwakho nzuzo zezimali iqhaza kulolu cwaningo. Uyothola bazibandakanye okungenani amabili noma ngaphezulu elilodwa kuya elilodwa interview, kuye ngokuthi ukuzimisela kwakho, futhi ngayinye kungathatha imizuzu 45 no umhlangano ube focus iqembu nezinye ababambiqhaza, okuyinto izothatha ihora nengxenye. Mihlangano kuyoba ngasikhathi ekamelweni inkomfa noma yiluphi olunye indawo ye choice yakho nenduduzo ngaphakathi imvelo esibhedlela noma ekhaya lakho. Ngithemba ukuthi kuzothatha isikhathi ukuba iqhaza

.

Uma kukhona imibuzo noma ukukhathazeka mayelana iqhaza kulolu cwaningo, ungaxhumana nami, umphathi wami, noma ehhovisi ucwaningo eNyuvesi ngokusebenzisa izinombolo ohlwini ngenhla.

Yours Sincerely,

Gabriel Gyang Darong

Investigator's Signature_____ Date _____

APPENDIX 4.1: Informed Consent Form (English)

UNIVERSITY OF KWAZULU-NATAL

SCHOOL OF SOCIAL SCIENCES

Fieldworker: Gabriel Gyang Darong (0785863009)

Supervisor: Dr. Maheshvari Naidu (031-2607657)

Research Office: Ms P Ximba 031-2603587

I _____ (**optional** and may be replaced by initials) hereby declare that I am fully informed about the nature of the research titled: **The Cultural Construction of Illness amongst *isi*Zulu-speaking Nurses: Probing Nurses' understanding of Patient's illness and Health in Hospitals,** by the researcher.

Yes…… **No……**

I have also been well informed about the role that I stand to play if I am to participate in this project, which is participating in a one to one interview and in a focus group meeting. I am also aware that participation is voluntary and I can choose to withdraw from the process at any stage without any consequences to my withdrawal. **Yes……..** **No…….**

I am aware that all information obtained from me in the course of this project will remain confidential and that my identity will be well guided in the case of any publication of the obtained information.

Yes…… **No……..**

I agree that the interview process will be electronically recorded and all collected information will be kept with confidentiality and high security. **Yes……** **No……..**

_____	_____	_____	_____
Initials	Signature	Date	Place

Gender	Year of Birth	Years of Practice	Position in Hospital	Current Department/Duty Post

I Gabriel Gyang Darong do solemnly declare that I have fully informed the above participant of the nature and purpose of my research and the demands involved in his/her participation. I also declare to do all in my power to maintain confidentiality and anonymity of the participant as I fully keep to the ethical conduct requested of me as a fieldworker.

_____ _____ _____

Signature Date Place

APPENDIX 4.2: Informed Consent Form (*isi*Zulu)

UNIVERSITY OF KWAZULU-NATAL

SCHOOL OF SOCIAL SCIENCES

Fieldworker: Gabriel Gyang Darong (0785863009)

Supervisor: Dr. Maheshvari Naidu (031-2607657)

Research Office: Ms P Ximba 031-2603587

Mina _____ (uyazikhethela kanti bangase esikhundleni salo kube zokuqala) umemezela ukuthi ngingubani unolwazi ngokugcwele ebabuza socwaningo osesikhundleni: I Cultural Ukwakhiwa Kokugula phakathi abahlengikazi abakhuluma *isi*Zulu-abahlengikazi: ukuqonda kumba Abahlengikazi 'yokugula Lesiguli Nempilo ezibhedlela, yilo umcwaningi.
Yebo ..... Akukho .....

I nazo bezilokhu kahle ukwaziswa indima ngimi ukudlala noma ngingenalo ukwenza lo msebenzi, lokuyintfo iqhaza engxoxweni eyodwa kwenye futhi emhlanganweni focus iqembu . I am Godu uyazi ukuthi kubalulekile yokuzithandela futhi ngiyakwazi ukhetha sishiye inqubo azibize ngaphandle nokuthi kuzokwenzekani zokuqaleka yami.

Yebo ..... Akukho .....

Ngiyazi ukuthi lonke ulwazi etholwe kimi phakathi msebenzi izohlala oluyimfihlo nokuthi ungubani lami kahle waqondisa endabeni noma iyiphi kushicilelwe ulwazi eyatholakala.
Yebo ..... Akukho .....

Ngiyavuma ukuthi inqubo interview uzobe nge aqoshiwe kanti lonke ulwazi oluqoqwe azohlala ne zobumfihlo nokuphepha eliphezulu. Yebo ..... Akukho .....

---------- ---------- ---------- ----------

zokuqala isiginesha Usuku indawo

Ubulili	**Yobudala**	**Iminyaka Umkhuba**	**Isikhundla Isibhedlela**	**yamanje Mnyango / duty Post**

Mina Gabriel Darong Gyang ingabe nenza amemezele ukuthi ngiyinikele ukwaziswa ngokugcwele iqhaza ngenhla we isimo kanye nenhloso yocwaningo yami izimfuno bahileleke yakhe/iqhaza wakhe. Ngiphinde amemezele ukwenza konke okusemandleni ami ukuba alondoloze imfihlo nokungazani we obambe iqhaza njengoba ngiqhubeka ngokugcwele ukuziphatha sokuziphatha eceliwe ngami njengendlela fieldworker.

_____ _____ _____

isiginesha Usuku indawo

APPENDIX 5: Skeletal Demography of Research Participants

S/N	NAME	GENDER	AGE	MEDICAL TITLE	NURSING YEARS	CURRENT DEPARTMENT
1	Sr. Zama	Female	49	Professional Nurse/Midwife/ Psychotherapist	24	Children's Ward (Unite Matron)
2	Sr. Nelisiwe	Female	48	Professional Nurse/Midwife/ Psychotherapist	23	Maternity Ward (Unit Matron)
3	Sr. Sindiswa	Female	49	Professional Nurse/Midwife/ Psychotherapist	20	Medical Ward (Unit Matron
4	Sr. Nosipho	Female	48	Professional Nurse/Midwife	20	Maternity Ward (Senior Staff)
5	Sr. Xoliswa	Female	47	Sister/Professional Nurse	19	Surgical Ward
6	Sr. Anele	Female	50	Professional Nurse/Midwife/ Psychotherapist	19	Maternity Ward
7	Sr. Mpume	Female	49	Professional Nurse/Dentist	18	Out Patients' Department
8	Sr. Duduzile	Female	45	Sister/Professional Nurse	18	Out Patients' Department
9	Sr. Khanyisile	Female	45	Sister/Professional Nurse	17	Surgical Ward
10	Sr. Nolwazi	Female	48	Professional Nurse/Midwife/ Psychotherapist	16	Maternity Ward
11	Sr. Sibongile	Female	41	Sister/Professional Nurse	15	Out Patients' Department
12	Sr. Thabile	Female	35	Sister/Professional Nurse	13	Children's Ward
13	Sr. Andiswa	Female	39	Professional Nurse/Midwife/ Psychotherapist	12	Children's Ward (Senior Staff)

14	Sr. Phindile	Female	47	Professional Nurse/Midwife/ Psychotherapist	10	Maternity Ward (Acting Unit Manager)
15	Sr. Nothando	Female	36	Professional Nurse/Midwife/ Psychotherapist	10	Maternity Ward
16	Sir Jabulani	Male	31	Sir/Professional Nurse	7	Out Patients' Department
17	Sir Thabiso	Male	34	Sir/Professional Nurse	6	Male Medical Ward
18	Sir Siyanda	Male	32	Sir/Professional Nurse	5	Female Medical Ward
19	Sr Nontokozo	Female	31	Sister/Professional Nurse	4	Out Patients' Department
20	Sir Wandile	Male	30	Sir/Professional Nurse	4	Surgical Ward

Note: Participants are arranged based on their years of experience in a descending order

APPENDIX 6: Researcher's Interview Schedule/Questions' Guide

1. What does it mean to be ill?

2. Are there any illnesses that you can mention and what you think causes them?

3. Are you able to treat all illnesses you are met with here in the hospital?

4. What are the situations where you are unable to treat an illness?

5. What do you do with patients that you feel have illnesses that you are unable to treat or you are not able to offer them the healing they need?

6. Do you ever feel the urge to suggest alternative treatment procedures to them, and what do you do in such situations?

7. What type of alternative treatment do you usually suggests or feel the urge to suggest?

7.1: Is the hospital aware of such alternatives and does it support them?

- If it supports them, in what practical ways does it support them?

- If it does not support, why do they not support such alternatives?

- Do you think the hospital should support such alternatives, and why?

7.2: What are the possible effects of being found referring patients to a treatment procedure that may not be supported by the hospital?

8. Do you have avenues to share such experiences and challenges, if yes, how are those challenges addressed and does the outcome satisfy you and the patients' needs? If no, do you think there is need for such, if yes, how can it be introduced and what are its possible values, if no, why?

9. Have you ever experienced a patient whose illness is biomedically diagnosed and treatable yet refuse their medication due to their traditional beliefs, and what do you do in such situations?

10. Do you feel that the current biomedical approach to illness gives enough room for the understanding and treatment of culturally-understood illnesses accordingly, is yes, how and if no, why?

11. Do you feel there is anything that can be done to better the understanding of patients' illnesses? If yes, what are these possibilities?

12. What is the general reaction of doctors to patients who claim to be suffering from a culturally-based illness?

13. What do you do regarding the doctor's recommendation and why act that way?

14. Do you feel that the approach in the hospital takes care of all the cultural health beliefs and needs of patients? If no, what are those uncarted scenarios and what will you suggest should be done?

15. How do *isangoma* nurses view illness?

16. How are you able to know what a patient is suffering from, here in the hospital at when you are visited at home?

17. What are the healing rituals you use in healing?

18. Is it possible to make use of the same healing in the hospital? If yes, how, if no, why?

NOTE:

-These questions were only a guide to the interviewer during interviews and discussions.

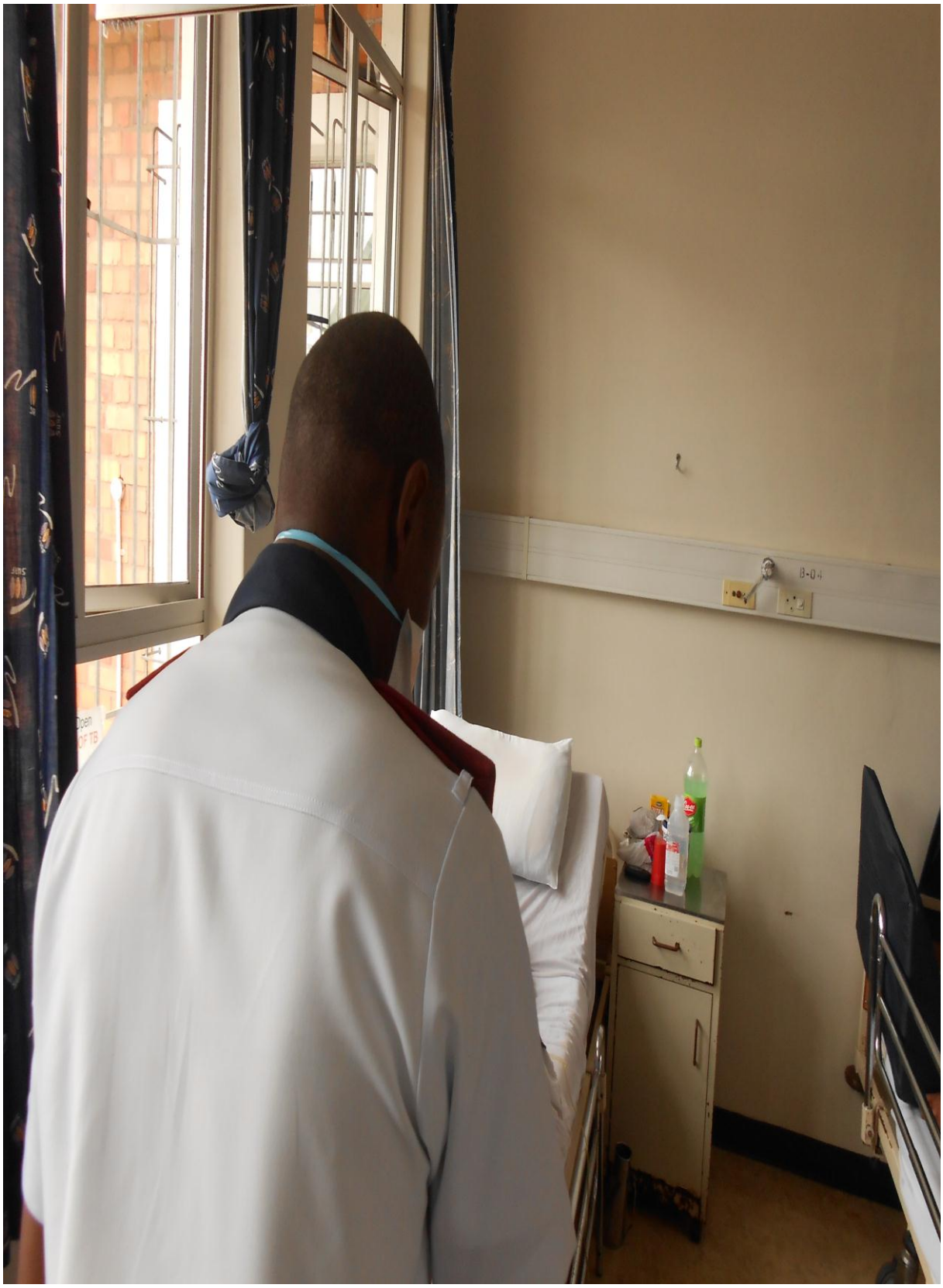
-Because the interviews were open-ended, there would have been questions that were spontaneously asked but not necessarily captured in the original questions' guide.

-These questions were not strictly asked as ordered here.

-Questions 1 - 14 were asked to all nurses including the *isangoma* nurses, while 15 - 18 were only asked to the *isangoma* nurses.

APPENDIX 7: Sr. Phindile and Sr. Anele in the Maternity Ward

APPENDIX 8: Sir Thabiso in the Male Medical Ward



APPENDIX 9: Sr. Mpume Showing How She Throws Bones

APPENDIX 10: Sr. Nelisiwe Lighting the Candles before Praying and Offering a Goat during a Ritual

APPENDIX 11: Sr. Mpume in her Prayer Position in her "Consultation Room"

APPENDIX 12: Sr. Andiswa in the Children's' Ward