Ukufa KwaBantu

Essential CME is a series of topics involving a continuous self learning and appraisal process in family practice for general practitioners, primary care physicians and generalist medical officers.

This is number twenty-four in the series and is on Ukufa KwaBantu.

Benchmarks for Busy GPs

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This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.

Although I have practised in a cross-cultural context for over 20 years, I have found this to be the most difficult subject of the series to write on. Very little has been written on these conditions and interrelationships from the perspective of general practice. It is also a difficult subject to approach because as an author one is influenced and restricted to one's own specific cultural setting. My cultural background is A A P (Average Arrogant Pom) and as a white GP it is very easy to slip into US (white GP) and THEM (black patients) mode without acknowledging that we are all in this pot together as white and black, female and male, doctors and patients.

Most white GPs when consulting with black patients have a vague idea of the patient's beliefs concerning witchcraft, traditional healers and rituals, which they have picked up along the way from various sources.

There is, however, very little formal teaching on the subject and most western doctors are largely unaware of the patients' ideas about the causes of their illnesses or their concepts of health and ill-health.

It should be remembered, though, that cross-cultural difficulties are not strictly a white/black phenomenon but occur in black/black and white/white consultations as well. Assumptions that health beliefs are the same because one is dealing with a patient from the same culture as oneself is often erroneous.

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In this way, almost all consultations are multicultural in one way or another. *(Kruger, 1980)*

"There's something going on here that doesn't add up"

You have just arrived from Cuba and your first patient is a Zulu, who gives rather a vague history and complains of abdominal pains. He is not able to point to exactly where the pain is. He is also feeling weak and has a loss of appetite. Your examination is unsatisfactory in the way that it reveals some possible tenderness in the epigastrium but nothing very definite.

Your provisional diagnosis is possibly gastritis, possibly irritable bowel syndrome or even peptic ulcer although you have heard that this is not so common in Zulus (but is on the increase). The diagnosis is, in fact, idliso. The patient may even present this as a possible cause although this is rarely volunteered. Your interpreter will know the diagnosis is idliso but she will probably not voluntarily tell you either because you may not understand about **ukufa kwabantu.**

What does **ukufa kwaBantu** mean? In direct translation from the Zulu it means 'African or Bantu disease' (fa means to be ill or suffer or to die). Usually it is given as an explanation by relatives of a patient to a western trained doctor that they feel the patient is suffering in a different dimension than the biomedical or technical framework of western medicine. It is an attempt to explain the spirit world and cultural traditions and fears as a cause of the patient's illness.

Ukufa kwabantu has been defined as "those culture-bound syndromes which the Zulu people themselves believe are unique or peculiar to their people in the sense that their aetiology, diagnosis and treatment are all inextricably bound up with traditional African world views of sickness and health". *(Edwards et al, 1982)*

A culture-bound syndrome is a disorder (usually psychiatric) which is influenced by and restricted to a specific cultural setting. *(Freedman, 1976)*. But this is really a misnomer because all disorders are bound to a culture. Culture specific or based or culture-specific disease phenomenon are more accurate terms.

Ukufa kwabantu has been explained in a similar way as 'disease of the African peoples' *(Ngubane, 1977, p.24)* but that this does not mean 'that the disease, or rather their symptoms, are seen as associated with African people only, but that their interpretation is bound up with African ways of viewing health and disease'.

The term culture refers to 'the body of shared attitudes, values and habits that is conveyed by a society to its members' *(Shepherd & Zangwill, 1883)*.

This collection of conditions can be more group specific, for instance, ukufa kwamaXhosa means literally illness of the Xhosa people.

Ukufa kwamaXhosa may be defined as 'illnesses found among the Xhosa-speaking people with a 'supernatural' cause in terms of the Xhosa magico-religious tradition'. *(de Villiers, 1991)*

In Northern Sotho or Pedi, **Malwetsi a Batho** and in Southern Sotho **Mafu a Batho** are the equivalent concepts to ukufa kwaBantu.

In Northern Sotho or Pedi, **Ke dilo tsa batho** which literally means 'these are people's affairs' carries the broader interpretation of bewitchment and **o na le badimo** is interpreted as a call from the ancestors.

Usually patients will not tell the doctor directly of these interpretations or mention them, so many doctors will not have heard these phrases.

Some attach narrower meanings to the concept of ukufa kwabantu. Some con-

sider it refers exclusively to ancestrally caused illness and on other occasions it may refer to the 'calling' (ukuthwasa) from the ancestral spirits to be a diviner or to perform ritual ceremonies.

In fact, the general concept of ukufa kwaBantu is broader than just these culture specific syndromes and it does not necessarily apply to psychiatric syndromes. It applies to a wide interpretative framework and is a way of explaining and understanding illnesses and other states of disturbance in our personal worlds **that really applies to all cultures.**

The perceived difference between 'illnesses of the people' and 'ordinary' illness is partly explained by the definition of disease and of illness. Disease is doctor-orientated, mechanistic and understandable as the body as a 'broken machine' that is to be mended, whereas illness is the perceptions, feelings, beliefs and interpretations that the patient gives to his condition.

It is fairly similar to the dichotomy in western countries between 'orthodox' medicine and 'alternative' medicine. It is the interface between science and magic and between reason and faith.

One of the main problems encountered is that of the language used. Words like witchcraft, sacrifice and ancestor worship are heavy with prejudice and have many different meanings. Witchcraft can be used as a very broad lay term or as a specific anthropological definition. Sacrifice can carry innuendos of paganism (whatever that means) and can be misinterpreted from the symbols they represent. Ancestors are not worshipped in the sense of deities but addressed as in communion.

It has been observed that illness can impair the faculty of reason in anyone of any race. The most rational of people may become irrational and superstitious *(Cassell, 1976)*.

It is also important to remember that culture-based syndromes are common to all peoples of all cultures. They reflect the problems of living of a specific community as seen by an outsider.

We, as general practitioners, tend to regard all disorders as the same amongst all societies from our medical point of view. Where the difference occurs is from the patient's point of view in that he or she explains, interprets and treats the disorder according to the society that he or she comes from.

In researching this subject it is important not to generalise from the 'Nguni' (Zulu, Xhosa etc) culture to the whole of South Africa. Most research and documentation has been done on Zulu culture and they are the main examples given here. There are similar threads that run through most African cultures and, indeed, all cultures. For instance, umhayizo parallels piblokto (arctic hysteria) of the Eskimos, idliso resembles malgri of the Australian Aborigines and ukudlula is similar to makutu of the New Zealand Maoris.

This has now become an immensely confused field of study because of the population movements and urbanisation that bring different cultures and traditions together. In the cities of South Africa these culture-based syndromes become distorted or altered often out of all recognition from the specific rural cultures from which they originated. This is compounded by an increase in the number of inexperienced or self-taught traditional healers or faith healers who misdiagnose or label the patient in an illogical way.

Another reason for difficulty in the research of these subjects is that each person that I have consulted has given me a different opinion or interpretation of meanings or events. Even though these differences are often slight it creates a delightful harmony of confusions in the mind of the listener and emphasises one of the themes of this area of human communication and that is that

although we have group or national characteristics and customs, these are also interpreted on an individual basis.

One of the clinical and diagnostic challenges facing the general practitioner is to differentiate between serious mental illness and the less serious problems of anxiety neurosis etc or problems that are manageable on a primary care level. Serious mental illness such a schizophrenia, severe depressions and toxic psychoses, which have already been culturally interpreted by the patient and his or her family raise the ethical problems of patient autonomy/patient advocacy when one considers intervention and referral.

With these conditions the good consultation and assessment will help improve the communication and outcome. If the patient is viewed as a whole, is assessed comprehensively and holistically and is listened to and not interrupted then much can be accomplished. Medical diagnoses can be made and conditions treated in an integrated way whilst addressing individual meanings, explaining the conditions, educating and being aware of the contexts that the patients come from.

General practice/family medicine is the ideal discipline in which research in this area of cross-cultural medical care can be carried out because we are often the first or only western orientated contact with these conditions. One suspects that they come to the general practitioner for his personal characteristics rather than solely for his technical expertise. The relationship appears to be more personal and based on trust. I once suggested referral of a patient in this context to a psychiatrist. The patient replied (referring to the psychiatrist) "but he is another person, not you".

One of the reasons for the gap between modern and traditional views is the changes that have occurred in the western world, in the past thirty years or so. The West has had many of its psychological problems explained to it by the information explosion in the popular media. We all know and discuss our anxiety states, depressions, bulimias (this is the Royal 'we') in a more open way than we used to.

This has not pervaded into the more traditional societies yet and one must be careful of this.

As Isak Dinesen (Karen Blixen) says in Shadows on the Grass, "We, nations of Europe....who do not fear to floodlight our own inmost mechanisms, are here turning the blazing lights of civilisation into dark eyes. If for a long enough time we continue, in this way, to dazzle and blind the Africans, we may in the end bring upon them a longing for darkness, which will drive them into the gorges of their own, unknown mountains and their own, unknown minds" *(Dinesen, 1961)*.

My point (I think) is that one must be careful not to impose one's own cultural categories on others in a sort of medical imperialistic way. Much of medical practice is based on the predominant culture of the west and therefore geared to the expectations and needs of the western patient.

In fact, 'the blazing lights' of so-called civilisation makes most of us long for the darkness.

Last in the line

"Doctor, for the time being you must be satisfied with being the last resort in the health problems of the Bantu" *(Schimlek, 1950:91)*
Up to 80% of the patients who come to see the general practitioner have first seen a traditional healer. Couple this fact with the fact that there are about 200,000 traditional healers (out of an estimated million or more) recognised by the Southern African Traditional Healers' Council (SATHC) means that **traditional healers are able to exist in such large numbers because the**

western health care system is unable to satisfy the needs of the people. These patients come to the modern doctor for treatment of illness problems, which are not addressed properly by disease-orientated doctors. Patients wanting to talk, wait in queues for doctors who haven't got the time to listen.

Somehow proton pump inhibitors, selective serotonin reuptake inhibitors and twentieth generation cephalosporins don't seem to have reached the soul of man (yet).
(Erasmus, 1992; Abdool Karim et al, 1994)

Why then do these patients come to see us?

Many patients find themselves caught in 'two worlds'. Young black women find themselves pressurised by the older black traditional women on the one hand and by the older white madam on the other. In between is a sick baby.

They come to the western doctor because of the medical treatment, reassurance and a straight diagnosis (and because the white madam pays; this is what I would call a consultation under duress and is an interesting uninvestigated dynamic of the consultation process).

Disease and illness

Much of what is addressed here centres around the distinction between disease and illness and curing and healing. To illustrate this we can return to your patient with idliso (sorcery where a harmful substance is put in the food) and your recent arrival in Natal from Cuba or Pretoria. You have come to a final diagnosis of alcoholic gastritis and treated him with antacids, vitamins and some evangelical admonishments.

What has been missed is that he thinks his wife is trying to poison him (idliso) because he has got a young girl friend, at his workplace in the city, about whom he feels guilty. Things are not going so well at home and he is consequently drinking to much. You have diagnosed **the disease and he is feeling ill.**

Disease in the western medical view is the malfunctioning or maladaptation of biological and psychophysiological processes in the individual ('the broken machine').

Illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Illness is shaped by cultural factors governing perception, labelling, the explanation and the value attached to the experience. These processes are embedded in a complex family, social and cultural background and context. Illness is **culturally constructed and socially created.**

Disease and illness are concepts only and should not be separated as distinct entities but viewed as differing explanatory models and may be united under the human experience of **sickness.**
(Kleinman et al, 1978, 1979)

Curing refers to practices which are efficacious, *from the point of view of biomedical science*, in either reversing, limiting or preventing disease.

Healing refers to practices which are efficacious, *from the point of view of the patient and his or her perceptions and experiences*, and which affect, for the better, illness, disease and other socially disvalued states. (Young, 1983)

Turning dis-ease into disease

"Whatever else illness is, and it is many things-an unfortunate brush with nature, a fall from grace, a social rupture, a cosmic disequilibrium-it is also, at times an act of refusal" *(Scheper-Hughes, 1994)*

We must be careful not to strip away the social content and political meanings of suffering. Symptoms may be the cryptic language of distress. Some forms of physical illness and mental illness can be viewed as masked acts of refusal and as a protest against oppressive social roles and ideologies. This has been

called the Rebel Body which is unruly and has chaotic symptoms and disrespects our medical classifications. Medical anthropologists propose that this may represent feelings of oppression, frustration and submerged rage.

Searching for a cause

"All men, whether primitive or civilised, have a drive to explain and to this end build models to assist thought." Hammond-Tooke, 1972

"Modern medicine explains 'what' and even 'how'. What the traditional person wants to know is 'why?' *Dr Ian Couper, KwaNgwanase.*

Man needs an explanation or reason for his diseases and suffering. Technology and an understanding of the biology of the body has given western man these explanations in an understandable and rational manner via mechanistic explanations. Furthermore, many western patients have reached a stage, when discussing the cause of an illness, of accepting the explanation of 'it is not known'.

However, people with traditional beliefs almost always believe there is a 'cause' and still explain illness and disease partly via the influences of spiritual forces, ancestors and witchcraft.

In fact we may all do this to some extent or other only by different words and in different cultural ways. The traditional patient comes to the western doctor with two (albeit often unarticulated) questions, "Why am I ill?" and "Who made me ill?" *(Daynes & Msengi, 1979).*

Depending on the patient's frame of reference any condition can be attributed to witchcraft from diabetes to eczema to accidents.

The commonest illnesses that are influenced by this tension between western and traditional thought are anxiety/depressive states, psychoses and disease states such as tuberculosis and epilepsy. The clinical and mental picture is often made more complex by alcohol, cannabis and drug abuse.

Attempts to make sense of the world depends on one's world view which involves not only intellectual reasoning but emotions and value systems.

Human response to a sudden crisis (eg cancer) may be explained, within the medical paradigm, by three broad categories: chance, heredity and unhealthy life style. Within a traditional system mystical forces are included in the categories of causation.

One of the confusing experiences that rural people have with western health care is this lack of explanation that is given to the patient. This is related to lack of time, poor language skills, an inability of the doctor to 'connect' with the patients' frame of reference and an insensitivity to the patient's socio-cultural context (Hugo, 1992).

THE MISTAKE OF CATEGORISING PEOPLES

"Western and traditional medicine have tended to be enveloped in a romantic aura:-western medicine as the apotheosis of rationality and scientific virtuosity, and traditional healing as the mysterious, secret lore of an enigmatic Africa. The reality is different." *(Hammond-Tooke, 1989, p.10)*

"Doctors have a very specific and narrow culture and language, and we impose this on our patients unwittingly by insisting on interpreting every patient offer as part of a disease syndrome" *(Dr Steve Reid, McCord Hospital, Durban, 1996)*

It is a common mistake in South African general practice to assume that white patients or higher socioeconomic groups have rational views on health and do not have inner superstitions,

beliefs and traditions. These are inheritances and properties of all peoples and all races. Likewise it is a mistake to assume that a black patient does not have a rational, scientific approach to illnesses. Black or white doctors treating black or white patients face a multitude of differing dynamics in cross-cultural consultations in which it is often difficult to remove one's own preconceptions, beliefs and cultural influences.

It is not always necessary or possible to remove these influences but it is important to be aware that these influences exist. Awareness is often synonymous with valuing patients as persons (patient-centred care).

Cultural problems are not only ethnic. For instance, a Xhosa doctor who has grown up in Soweto may not necessarily have the same cultural background as a Xhosa patient from the Transkei. They may share a broad language and a culture but not necessarily a subculture.

"Language does not = culture" (A A Jaques)

WESTERN EQUIVALENTS OF UKUFA KWABANTU

One could propose (I am just putting this up for debate) that the western equivalents of ukufa kwabantu could be such medicalisations as post-traumatic stress disorder, premenstrual syndrome, the menopause and mid-life crisis, burnout and chronic fatigue syndrome. They are new, chronic disabling 'diseases' which DSM has named and classified. They are often culturally derived and socially structured. Post-traumatic stress disorder may have political and social meanings, premenstrual tension may represent an inability by medicine to accept female irritability and suppressed rage, the 'invention' of the menopause and mid-life crisis may be medicalised expressions of ageing, frustration and gender roles.

Anorexia nervosa has also been described as a western culture-bound syndrome (Jorsh, 1993) and I must admit I have never seen this condition in a South African black patient. Only five cases had been described in black Africa by the end of the eighties. I suspect, though, that it will start to be seen more frequently as further westernisation of the black people occurs. In fact this is happening in social life as 'thin' is 'in' for the modern black woman in contrast to the traditional woman's more Rubenesque outline. Other western culture-bound syndromes associated with health are the cultures of 'wellness' such as jogging, aerobics, health gyms etc.

Two different world-views

Different peoples have different world views. It is not that they think differently (the thought processes are the same) but that the **categories of thought** are not the same. The dimensions and approaches and points of departure (eg where they are coming from) are not the same. These categories of thought or the direction from which a subject is approached is inculcated from childhood through the socialisation process. For instance a western approach (occidental) may be analytical and directive whereas an eastern approach (oriental) might accept things as they are (fatalistic).

Traditional people, on the other hand, may come from a world where all things are connected with the rhythms of natural and spiritual forces.

World-views are not an all-or-none affair as the human mind is quite capable of holding conflicting beliefs at one and the same time. These world-views are said to characterised by cultural 'universals' such as the notion of time and space. The content, as it were, of these universals manifest themselves differently from culture to culture. *(Hammond-Tooke, 1989)*

'Colonial' world views and 'traditional' world views

The old Zulu world-view had a High Law of Life which stated "Man, know that

your life is not your own. You live merely to link your ancestors with your descendants. Your duty is to beget children even while you keep the spirits of your ancestors alive through regular sacrifices. When your ancestors command you to die, do so with no regrets" *(Mutwa, 1964, p.507).*

A cross-cultural view of patients from the aspect of an Imperialistic Eurocentric culture was described by Karen Blixen (1937, p.96). I quote this with some trepidation in the New South Africa but it makes a good illustration of a gulf that has still to be crossed:

"The natives, if not paralysed and benumbed by their terror of the unknown, growl and grumble much in hospital, and invent schemes for getting away. Death is one of these; they do not fear it. The Europeans who have built and equipped the hospitals, and who are working in them, and have with much trouble got the patients dragged there, complain with bitterness that the natives know nothing of gratitude, and that it is the same whatever you do to them".

This passivity, she describes, probably means the patients are now depressed as well. The key is in the preposition - doing 'to' not 'for' or 'with'.

She continues "to white people there is something vexatious and mortifying in this state of mind in the natives. It is indeed the same whatever you do to them; you can do but little, and whatever you do disappears, and will never be heard of again; they do not thank you, and bear you no malice, and even should you want to you cannot do anything about it. It is an alarming quality; it seems to annul your existence as an individual human being, and to inflict upon you a role not of your own choosing, as if you were a phenomenon of nature, as if you were the weather".

This description is rooted in a historical colonial perspective.

The reason I am belabouring this point is that many of us are still stuck in this 'colonial' perspective. The fact that traditional peoples are supposedly 'fatalistic' is an unexamined prejudice. This is a broad generalisation that could as well apply to the poor in the slums of Europe or the Ancient World. It can apply to any cultural group as the life views of people within groups are varied in reality and in expression.

The key distinction that has been missed here is that the traditional African does not divide the physical from the mental, social or spiritual aspects of his life. Life is a whole and everything affects everything else (the ultimate systems theory).

They want to escape from the hospital because only the physical part is being addressed. The patient is 'ungrateful' that the other aspects of his being are unaccepted.

This dichotomy is similar to the concept of original sin, not necessarily in the true religious sense but in the sense of acceptance of man as an imperfect human being. It is this acceptance that is frustrating to the alternative and newer concept of the perfectibility of man, which is a state in which modern man does not just accept things as they are but attempts to do something about it. He strives to insure against the unknown and to combat the assaults of disease and fate with modern technology and reasoning. To illustrate this concept Rudolf Klein compares the health attitudes of Britain and America. "Britain" he says" is an original sin society in which illness and debility are seen as part of the natural order of things and patients tend to be deferential. America is a perfectibility of man society in which illness and debility are seen as challenges to action and patients tend to be demanding consumers".

Impilo, the concept of health

Impilo is literally translated as health but it means more than this. It means 'fullness of life' and is a prime concept

in African culture. To be without impilo means to be ill (ukufa). When man has impilo his relations with his natural and cultural environment are healthy.

When a patient seeks the help of a doctor or diviner he may not only be looking for a cure for an ailment but also for the balance of his or her life to be restored (similar to the ying and the yang). The traditional healer is therefore often consulted for this purpose of restoring harmony and balance both with one's environment and with one's ancestors. This may involve re-examining the cause of the misfortune, apportioning blame and, if appropriate, performing purification rituals and re-integrating the patient into his society. *(De Villiers, 1993).*

World-views of South Africans with traditional beliefs

These are four broadly defined approaches which purport to explain the human condition. As many traditional people (but not all) are unfamiliar with the workings of the human body, the causes of illness may be explained in terms of the magico-religious tradition.

The Supreme Being which postulates a creator God. This concept is vague with God as a shadowy figure who is not usually prayed to. He is usually contacted through the ancestral spirits. This supreme being is a residual explanatory concept much like the concepts of 'luck', 'chance' or 'fate'.

Ancestors are believed to look after the interests of their descendants. This provides an explanation of sickness or misfortune because the ancestors are moved to wrath mainly due to their descendants neglecting the customs of the house or family rituals or failure to accord due respect to seniors. There are special terms for ancestors such as amadlozi or amathongo (Zulu), amathongo or izinyanya (Xhosa), sikwembu (Tsonga), badimo (sotho), midzimu (Venda).

Witchcraft is the belief that certain individuals, driven by envy and malice, send mythical animals to harm others. Bewitchment can also be via a third person who may not know that he or she is the carrier of the bewitchment. Sorcery (ubuthakathi) is different in that medicines are used to harm and destroy. There can be night, day and lineage sorcery. In the main, witches are believed to be women and sorcerers men.

If patients who are bewitched are fully assessed psychologically, the cause of their condition almost always turns out to due to problematic interpersonal relationships such as rivalry between siblings or conflicts over promotion or disputes over women, cattle and crops and the general competition for scarce resources *(Schoeman, 1996).*

Pollution refers to a state of ritual impurity in which people find themselves, often inadvertently. The difference between these beliefs concerning pollution and others is that the illness is not sent by a person or spirit but is impersonal and caused by such things as sexual intercourse with a menstruating women, persons who have handled corpses, etc. *(Junod, 1962; Ngubane, 1977, Hammond-Tooke, 1989)*

Explanations have also been divided in other ways, eg. into biological factors, social, religious and magical factors *(Cheetham & Griffiths, 1982).*

New phenomena in Black Magico-Religious systems

The possession by alien spirits and the black Pentecostal churches are two relatively new phenomena that have given explanations to illnesses and life situations.

Possession which involves the possession of individuals by alien spirits. It is not ancestor orientated and should not be confused with Nguni-type divination, which is a form of spirit-mediumship, not possession.

Faith healing is a dimension that has

been included in the wave of South African Black Christianity. The leaders are called prophet healers. There are, broadly speaking, two types which are the Ethiopian, which is fairly orthodox in doctrine and the Zionist, which is a form of pentecostalism and places great emphasis on the healing power of the Holy Spirit. It has been estimated that there are about 3 000 small independent sects of this Church. Zionist possession is attributed to the presence of the holy spirit or 'umoya'. It may present as belching, 'talking in tongues' and prophetic dreams.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 1V) has a new diagnostic category entitled **Religious or Spiritual Problem** which is culturally sensitive *(Turner et al, 1995).*

The Church/Zionist/Prophet/Faith healer aspect is becoming very strong especially in Gauteng, Northern Province and Mpumalanga and needs to be recognised.

(References: Junod, 1962; Edwards et al, 1982; Hammond-Tooke, 1989)

Colour symbolism in medicine

There are three important symbolic colours in Zulu medicine; black (mnyama), red (bomvu) and white (mhlophe). They are used serially in that order. The sequence is rigid and never reversed. Black and red are said to be equivocal, in that they stand for both goodness and badness; white represents only what is good. Treatment with coloured medicines is intended to establish a balance between a person and his or her environment. Black and red medicines expel what is bad from the body and strengthen the body against further attacks. White medicines are used to regain good health. This is a simplification of a complex way in which colours can symbolically represent various states between disease and health as well as other social and cultural situations. (It is well explained in Harriet Ngubane's Body and Mind in Zulu Medicine, 1977, see resource list).

Colour symbolism is perhaps one of the cultural universals of mankind. Those of you who are aficionados of the English Pantomime will have seen the fairy in white in a white spotlight (lots of cheers here) and the witch in black with a dark green or blue spotlight (lots of boos here).

Some dynamics of the cross-cultural consultation in white doctor/black Patient encounters

I find, as a western GP, that it is now becoming more difficult to assess from where my black and white patients are coming. Patients vary from being very traditional to very westernised. Even more difficult is the westernised professional black patient with traditional beliefs. I often think I am communicating on one level but am unaware of other levels of belief and background. For instance, I will diagnose fibromyalgia/ rheumatism, while the patient regards it as umkhondo. I am treating the disease while the patient is experiencing the illness.

Stuck on the horns of a trilemma

In fact one can find oneself working in three frames of reference at once. For example, I find the patient may present in a culturally-specific way as above and also have a medical disease such as tuberculosis, cancer, prostatic hypertrophy or infected eczema. The disease process may be the cause of the presenting symptoms in the first place or may be an unassociated finding on examination. On top of this dichotomy is my attempt to make another medical diagnosis in a psychiatric context such as neurosis, psychosomatic disorder, conversion disorder, fictitious disorder, hysteria, acute psychosis or confusional state.

This trichotomy reminds me of the definition of an eccentric as being half

artist, half lunatic and half poet. That's three halves, which make a whole.

More difficulties in the cross-cultural GP consultation

Understanding by the patient or the doctor can be blocked by respect, fear, protection and language difficulties.

After my clinic, I see the patients having it all explained properly by the sister or nursing assistant. This is after I have asked the patient if they have understood what is going on.

This, I am told, is to protect my dignity and they don't want to demean a person of my status (**uyamehlisa:** you are lowering his dignity) by asking me to repeat the details that they have not understood. This is similar to the Chinese custom of 'saving face'. Others respond out of respect for the senior status of the doctor and when asked if they have understood reply in the affirmative, even if this is not the case.

Some have been brought up with the idea that if you have to ask questions you were not listening properly. They are therefore afraid to ask. The initiative of the patients was also taken away in the past because of the previous politically white dominant position which invaded communication in all aspects of South African life including the doctor-patient relationship.

The custom of **ukuhlonipha** may also spill over into the doctor-patient relationship involving Zulu and Xhosa patients. This is because of the authoritative position of the doctor. **Ukuhlonipha** is the custom that a women should not address her husband's father or other senior male relatives directly. She should never, for instance, use their names. A type of distinctive language is used to communicate with such relatives. It is probable, especially with a woman patient and a male doctor, that these traditions will be carried over into the consultation. *(de Villiers, 1991.)* There are apparently almost 4 000 hlonipha words in the Zulu dictionary. **Inhlonipha** literally means respect.

Taking a history in this context is therefore difficult because the female patient is hesitant to talk about her problems. This is overcome by the traditional healer by the process of **vumisa.** In this process the healer will make statements rather than ask questions. The patient will answer **siyavuma** (I agree) to every statement. One theory is that the real answer is deduced from the way the patient answers.

In general practice these situations are usually now only encountered in rural areas with patients of little education. They tend to be a bit shocked when asked direct questions and their replies are guarded or vague.

Hlonipha (respect), for example, may prevent a childless woman from telling the doctor directly about her problem and she might complain of lower abdominal pain instead and hope that the doctor will discover her problem. This is done out of respect for her husband either because he may be infertile or that she is infertile and this reflects on him.

Some more approaches to the cross-cultural GP consultation

Most patients attending a western trained doctor go for 'disease treatment' rather than divination and know that this involves a battery of interrogatory questions.

Several techniques can be used to help the new general practitioner deal with this situation.

Information can be garnered by the sister or interpreter before the patient sees the doctor. The doctor is then informed verbally or the information is briefly written on the card as to the main complaints. I am informed that the patient often does not connect that this information will be given to the anonymous doctor behind the consulting room.

Given that most African outpatients are very rushed, I find it is worthwhile to 'wash one's mind' between consultations, have a Zen moment, calm down and slow down into the patient's time mode. The greeting and initial unhurried pace and equanimity of your composure (this sounds like its going to be a seance) may help the connection.

The Zulu word **indaba** conveys the atmosphere of these sort of consultations rather well. My interpreter refers to them as "this is one of your indaba patients, doctor".

I have sometimes taken to examining the patient after the greeting without asking questions. Some regard this as heresy but the physical connection of touch or auscultation of the chest with the stethoscope may immediately lead to the problem. It also helps with communication. I have the impression that after you have touched someone you can proceed on a different level and get freer answers to your questions than you would have done at those rather tense starts with a desk in between you and the patient. You can then go back again and re-examine as further information is received. I am not advocating hocus pocus and I'm not suggesting that you leap in with a speculum before taking your hat off but that the formal linear process of the western consultation does not necessarily have to be rigidly followed in every case.

The first few seconds

There is a song which goes "the minute you walked in the door (tiddly pom),....". In those few seconds as the patient walks into the room some of the most useful impressions, intuitions, connections and details are received by our conscious and unconscious minds. As one's experience grows one can almost predict by non-verbal communication how the consultation should be handled before the patient sits down. The eye contact and eye movement, the way the patient walks, the carriage of the body, the dress etc are absorbed by the doctor with an almost automatic Sherlock Holmesian inspection.

This initial impression often sets the way the consultation will go, eg in a disease-orientated or more person-orientated way.

There are two questions that often save hours of assessment: "Have you seen the traditional healer about this?" and "What did he say?". *(Henning, 1992).*

In fact all you often need say to is "What did she say?" and you may get the answer "She told me to come to you!" *(Daynes, 1996).*

The medical consultation and the traditional healer's consultation operate in different dimensions and systems but more and more patients use both systems for the same condition but for different reasons. It is interesting how we all compartmentalise our ideas and our perceptions. It depends on how we perceive the problem who we consult.
The potential for conflicting advice and confusion is very great unless the person treating us understands our perceptions of our problems.

As the process of transition speeds up and new measures for delivering health care are implemented these problems of aculturalisation will become more apparent.

A patient selects from the reality of his or her life 'bits' of information which conform to his or her beliefs about the world in which he or she lives. This is known as the ecology of ideas (Bateson, 1979). We all tend to develop personal, hybrid world-views that help us to make sense of our experiences and to order our lives. The modern day black man has to hybridise the traditional and modern worlds into some sort of sense *(Hammond-Tooke, 1989).*

Having said all this, it is important, in a cross-cultural consultation, not to assign a deeper meaning to every symptom and

illness. There is a range of illnesses that are thought by most people to 'just occur'. Many symptoms are taken at face value and are not given any special significance. Common coughs and colds **(umkhuhlane)** as well as even more serious illnesses may be accepted in a matter of fact way *(Ngubane, 1977, p.23)*.

Umkhuhlane is used as a generic term to describe any illness that 'just happens' or, by common usage, may refer to 'influenza' or upper respiratory tract infections. Most infectious diseases such as chickenpox and measles are accepted as natural processes as well as malaria and bilharzia.

Questions that help find out the patient's agenda

To find out how the patient views his or her illness (patient's explanatory model) the following questions may help:

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is it?
- What kind of treatment do you think you should receive?
- What do you hope to achieve from this treatment?
- What are the chief problems your sickness has caused you?
- What do you fear most about it?

Two more useful questions are:

- "Do you dream a lot?"
- "Do you think a lot? (Do you think at night if you are not sleeping well?)" If the answer is in the affirmative then you can ask: "What do you dream/think about?" This can reveal significant information. *(Reid, 1996)*

Obviously one can not ask all these questions in every consultation but eliciting the patient's ideas on causes and expectations are the most important. It is not a bad idea **to ask these questions of ourselves.**

It is not enough to ask the right questions, you have to listen to the answers as well. I cannot leave this without one of my favourite quotations from Henry David Thoreau: "It takes two to speak the truth-one to speak and another to hear".

(References: Kleinman, 1978; Deagle, 1986; McWhinney, 1989, p.94)

Reasons why patients do not ask the doctor more questions are:

1. They prefer to discuss the matter with the nurse.
2. The doctor was in a hurry.
3. They still intend doing so.
4. They think the doctor will not understand. (de Villiers, 1991)

INYOKA, INYONI, INYONGO AND IGAZI

There are many graphic idioms that attempt to explain intangible and abstract ideas concerning health and disease, life and death, religious and cosmic events.

Inyoka is a snake, inyoni is a bird, inyongo is bile and igazi is blood. These words can be translated literally to mean exactly what they say but their symbolic meanings are often very different. They may be used as generic terms that are describing local reasons for diseases. They may also be used as metaphors or symbols that represent distress, bewitchment or mental illness. They may also be misinterpretations or a confusion of unthought out beliefs.

Inyoka

Internal snakes are believed to inhabit the body of every individual in some tribes (eg. the Lovedu of the Transvaal lowveld) and stomach cramps and diarrhoea are explained by their movement

or 'biting'.

Nyoka is common to many African languages and crops up in many consultations and describes several different symptoms. In Shangaan (Tsonga) abdominal pain may be described as: nyoka ya luma (the snake is biting), constipation as: nyoka ya boha (the snake ties up), borborygmi as nyoka ya pfuma (the snake rumbles), diarrhoea as nyoka ya halata (the snakes pours), vomiting as nyoka ya ndzi hlantisa (the snake causes me to vomit).

The snake inside a person is also closely associated with fertility and childbirth. For instance, in Shangaan sterility is nyoka ayi khomi (the snake does not catch hold) or nyoka yi hundzulukile (the snake has turned around). A close expression to this is nyoka ya hundzuluka (the snake is turning around) has a very different meaning of bowel colic. *(Jaques, 1995)*

Among the Xhosa, inyoka yabafasi (the snake of women) is regarded as a witch's familiar and is seen as responsible for a sunken fontanelle in babies.

It is interesting that a snake around the staff of the caduceus is the sign of Asclepius. He was reputed to have been told the properties of plants by a serpent. The serpent of Asclepius was also the protector of the medicinal springs. (the snake seems to have had a pretty bad press over the years starting with some dodgy advice he gave in the garden of Eden)

Inyoni

Inyoni literally means bird. It is thought that lightning strikes in the form of a bird and that the fumes from the lightning contaminate the area around where the lightning strikes. Green diarrhoea and white-coated tongue are said to be the symptoms of inyoni among the Nyuswa-Zulu (Ngubane, 1977).
Inyoni enkulu is a serious form of diarrhoea and is thought to be associated with internal anal sores for which enemata are given *(Makathini, 1996)*.

In other areas sudden chest or abdominal pain are thought to be caused by the patient being kicked in the chest or abdomen by a heavenly bird with supernatural qualities *(Krige, 1950:310)*.

The lightning bird **(impundulu)** of the Zulu/Xhosa is also believed to cause miscarriages, blindness and death. *(Ngubane, 1977)*

Amongst the Xhosa the impundulu bird is only visible to its owner. Children are immune but all adults are at risk.

The symptoms are a cough, haemoptysis and chest pain and this has lead to it being given as an explanation for tuberculosis *(Stott & Browne, 1973)*.

Inyongo

Inyongo literally means gall or bile and is a common symptom which normally indicates gastrointestinal problems, gastritis, alcoholism or liver disorders (see Essential CME, gastroenterology, February 1995). The gall bladder and bile of the sacrificial beast are used in several sacrificial ceremonies and vomiting bile may be thought by the patient to be caused by poison or pollution.

An excessive accumulation of bile is said to cause headaches, biliousness and general debility. *(Ngubane, 1977)*.

Inflated gall bladders are used by some traditional healers in their headdress.
Inyongo is comparable in many ways to the term bilious in English.

Igazi

The blood is regarded in much the same way as in western practice in that the state of the blood is often believed to be the cause of many illnesses. It may be expressed by statements such as "The blood is finished or weak" or "I want something to clean the blood".

The Tsonga/Shangaan refer to "a blood'

(ngati) which moves from spot to spot before settling in the afflicted organ *(Junod, 1962)*.

The concept of the disorder of the blood is similar to the ancient morbid humours.

Iplate/Ipleti

This is a Zulu/Xhosa disease which is regarded as a new disease in the Transkei (brought from Zululand). Ipleti refers to a mythical malformed placenta and is referred to as 'just a plate' *(Ngubane, 1977:150)*.

It is attributed to a poison which crosses the placenta and damages the foetus. During the pregnancy the mother experiences backache and abdominal pain. The child is born at 7-8 months' gestation. It cries and breathes, but sucks weakly. Dark blue veins are visible on the placenta. If the child survives for more than a month it becomes marasmic. By invoking this ukufa kwamaxhosa, the mother can protect herself from accusations of faulty feeding habits. *(Stott & Browne, 1973)*

PSYCHIATRIC SYNDROMES

Mental illness, along with epilepsy, is commonly explained in terms of witchcraft, sorcery, pollution or the influence of ancestors.

The Pedi have a wide variety of explanations for psychiatric illnesses. Some explain madness as caused by the heart of the patient being filled with blood, with water, with a white substance and by a worm in the brain (Hammond-Tooke, 1989).

ZULU CULTURE-SPECIFIC PSYCHIATRIC SYNDROMES

The Zulu people traditionally distinguish categories of mental illness on the basis of their cause. These causes can be:

Sorcery:

a. ufufunyane, izizwe (alien spirit possession);
b. idliso, iqondo, bulawo, certain forms of umeqo (somatic symptoms), iloyo; and
c. umhayizo (hysterical symptoms);

Spirit possession:

a. Ukuthwasa (ancestral or divine calling), Zionist possession.
b. Indiki (by chance).

Ancestral wrath or displeasure: abaphansi basifulathele.

Asocial behaviour or ignoring social norms: ukulahla amasiko, ukudlula.

Pollution: umnyama, igazi elibi.

Environmental or atmospheric health hazards: certain forms of umeqo, umkhondo.

SOME ZULU CULTURE-BASED SYNDROMES

Ufufunyane is attributed to sorcery resulting in spirit possession. The symptoms range from hysteria and agitation to weeping, attempted suicide or aggression and delirium.

Amafufunyana among the Xhosa affects mainly women over the age of 13 years and can last for several days. The phenomenon of 'speaking in tongues' occurs but is usually heard in Xhosa, English or Afrikaans and thus is unlike the Pentecostal experience. This is thought to be a new disease that is spreading down from Zululand through the Transkei. *(Stott & Browne, 1973)*

Ufufunyane has been proposed as corresponding in western terminology to hysterical psychosis *(Wessels, 1983)*.

Izizwe (Amabutho) is attributed to possession by spirits of a foreign tribe. Symptoms are a speech disorder and rhythmic shaking of the body. It has some elements of 'talking in tongues'.

Idliso is attributed to the ingestion of

poison administered by someone else. Hence it is a type of sorcery. It usually occurs in situations of rivalry or jealousy. It may present as a confusional state or as symptoms related to the gastrointestinal tract. Interestingly idliso is the only manifestation of ukufa kwabantu that black patients regard as curable by a western practitioner, specifically through surgery.

Iqondo refers to a stone in the bladder that occurs in men who are guilty of illicit sexual intercourse. This condition may be assumed by patients who have an STD. Prostatitis, urinary problems and intestinal symptoms may also be blamed on iqondo.

Ibulawo/Iloyo may present as body pain, rheumatism, arthritis or swollen joints and is attributed to sorcery by poison.

Umhayizo (Ihabiya, Mpampa) occurs in young women due to love charms making them vulnerable to the man who has practised the sorcery. It presents as anxiety, fear, weeping and raving. It is thought to be associated with hysterical personality traits.

Umeqo is caused by stepping over dangerous tracks or placing harmful medicines in someone's pathway. Symptoms are variable and include painful joints, oedema of the ankles, arthritis or even hemiplegia. Umeqo is "the action of contracting a disease by stepping over dangerous tracts" *(Ngubane, 1997, p.25)*

Umkhondo may have an explanation similar to umeqo or may be explained along the lines of orthodox medicine's germ theory as it is attributed to invisible 'tracts' or a spoor that is left in the atmosphere. Traditional Zulus believe that, when moving, men and women leave behind something of themselves. What is left behind is known as umkhondo (tract). These tracts are both visible and invisible.

Indiki is the possession, by chance, of the wandering male spirit of, typically, a Swazi or Indian person. Symptoms are mental confusion, crying in a deep bellowing voice and speaking in a foreign tongue.

Abaphansi Basifulathele means 'the ancestors (those below) are facing away from us' and are not with us. It is due to ancestral wrath or displeasure due to the failure to perform appropriate ritual sacrifices. It can present as any unusual illness and also can presents as sterility in women and sickness in children.

UkuDlula is due to failure to observe socially acceptable behaviour during times associated with the major events of life and death. It may cause a person to commit sexual perversions or murder or similar antisocial behaviour. The closest medical diagnosis may be compulsion neurosis.

A person may suffer from ukuDlula if he or she disregards the practice of **ukuZila.** UkuZila literally means fasting but means more than just abstaining from food. For instance, a bereaved family will not sing, whistle, indulge in sexual intercourse, court, dance, work in the garden or plough. The life at this time is one of extreme restraint. If these practices are not observed then the person may suffer from ukuDlula *(Makathini, 1996).*

Iqungwa (iqungo) refers to a compulsive murderer. Traditionally the Zulus had to use purifying charms to cleanse themselves after killing in battle (Doke & Vilakazi, 1972). If this cleansing is not done the person is overcome by the spirit of his victim and kills compulsively. The igazi (blood) of his victim 'speaks'. A serial killer is a good example of iqungwa.

Umnyama (Umswazi) literally means 'darkness' and is associated with pollution. Pollution occurs when people are bereaved, during menstruation, during pregnancy or after birth and following sexual intercourse. Umnyama can be

passed on from one person to another. For instance, a widow who has not been ritually cleansed can pass it on to the first person that she has sexual intercourse with. *(Ngubane, 1977; Edwards et al, 1982)*

The above explanations are obviously simplistic and only briefly brush the surface of extremely complex human experiences. **They should not be taken as universal definitions as there are marked differences between different areas of South Africa.** Individuals (even in the same family) may also have markedly different interpretations and world-views on these illness experiences.

The other interesting thing is that these syndromes may not only be culture-bound but also 'area-bound' and only occur in certain areas within a broad cultural group such as the Zulus.

Thwasa

Spirit possession among the Xhosa is called intwaso but it is commonly written as thwasa. It is occurs in all Nguni people. Spirit possession usually occurs among marginal, subordinate and underprivileged people. It is characterised by a wide range of somatic, psychological and social symptoms. The most common are uvalo and umbilini (see below) and anxiety, fear and mental confusion. This mental confusion is called inhlathi (literally, a forest) because a forest is a place which lies outside the home and where one can easily get lost. One of the first signs may be withdrawal from normal social life. It is felt to be a stress-related disorder and is often the culmination of several stressful experiences. One theory is that it is an adaptive response to role and performance stress. It occurs mostly in married women who may have many conflicting roles to play in modern life such as to bear children, run a home without a husband yet be restricted by many traditional taboos. Men may also be afflicted due to role inadequacy, unemployment, loss of status etc. It is thus a response to economic and domestic insecurity and to rapidly changing traditional values and beliefs. *(O'Connell, 1982)*

It may be cured by animal sacrifices to the ancestors, but ideally the intwaso victim should go for training as a diviner (isangoma). Ukuthwasa means 'to come out' or to be reborn. (O'Connell, 1980). It is thus interpreted as a calling by the ancestors and can be defined as an 'emotional disturbance due to the ancestors' call to serve them' (Bührmann, 1984:12)

UVALO, UMBELINI AND SHIDYISO

The diagnosis of anxiety states is one of the more challenging situations in general practice. Anxiety presents in individual ways and is related to context and the influences of the local society and culture. Uvalo (Zulu), Umbelini (Xhosa) and Shidyiso (Shangaan) resemble the medical diagnosis of anxiety neurosis with somatic symptoms, eg. epigastric discomfort, palpitations etc. It is important, though, not to equate these culturally-based syndromes exactly with medical labels or diagnoses.

Uvalo is Zulu and means literally 'the pit of the stomach' and may be presented as **ukushaywa uvalo:** 'to be beaten by the pit of the stomach'. Its direct interpretation into English would be along the lines of 'nervous stomach' or 'butterflies' in the stomach. It may be associated with witchcraft, umhayizo or ukuthwasa. It has also been linked to alcoholism (the shivering of the delirium tremens). Other terms used are umqhuqho, umzuso or idumbe (shivering or unsteadiness).

I find there is a hesitation or reluctance to point to the exact area of discomfort. The hand hovers and hesitates over the upper abdomen. If pressed further the patient's fingers can point to both iliac fossae or suggest 'waist pain' while the interpreter, who has learnt his part well over the years from successive medical officers, fires more questions at the biological target.

Umbelini (Xhosa) literally means 'intestines'. It is generally used to describe a feeling of anxiety or anxious anticipation. There is a feeling of unease experienced in the chest or abdomen and palpitations. One could perhaps say it is a 'gut reaction'. It is a message from the interior of man. An interpreter at a consultation may translate umbelini as 'palpitations' to a European doctor who may assume the condition to be paroxysmal tachycardia and miss the message. **Inkaba,** the umbilicus, in Zulu, has similar mystical connotations.

Shidyiso (Tsonga/Shangaan) or **Idliso** (in Zulu) literally means 'that which you have eaten' or ' the thing you have been given to eat'. It is a syndrome that presents as a pain or discomfort in the epigastrium and chest. Typically the patient makes a clutching gesture in the epigastrium saying 'it catches me here!' and then moves his hand up over his sternum to his throat and says 'and then it closes me here'.

This closing of the throat neither impedes breathing nor swallowing and is more like a feeling of tightness of the throat.

The **shidyiso** is usually administered by someone else, usually as a malevolent act, to cause illness. It may also not be purposeful, in that it may occur as an involuntary phenomenon caused by a witch who is unaware of her powers (a **muloyi**).

The traditional cure of shidyiso is to induce a trance-like state in the course of a purification ceremony and then administering an emetic or purgative.
The difficulty, I find, is thinking on two different levels at once. I find myself in analytical mode of "Is this irritable bowel syndrome, duodenal ulcer etc?" and an exclusion routine to avoid missing pathology as well as looking for the real reason for the encounter. (All the more reason to do a three stage assessment, said the examiner).

The mere recognition and acceptance of these conditions by the doctor and answering in the same idiom helps the doctor establish rapport and confidence.

(References: Bryant, 1970; Ngubane, 1977; Edwards et al, 1982; Buhrmann, 1984; Conradie, 1990; Jaques, 1995)

SOME VENDA HEALTH BELIEFS

The Vendas live mostly in the far North East of the Northern Province. Some cultural health beliefs are:

- **Ndowela** (or ndolunwa) which means 'I've been bitten'. It is pollution caused when a man has sexual intercourse with a woman who has aborted. It is considered a dangerous disease, leading to death. It needs cleansing by the traditional healer or by injection and antibiotics.
- **Gokonya** refers to the affliction of pulsating fontanelle, or a baby with diarrhoea or if a baby has a birthmark on the nape of the neck. The treatment is to cut a piece from a rugae of the mother's vagina. This is either burnt with the mother's stools and the ash is then rubbed into cuts on the baby's head or it is boiled and given to the baby to drink.
- **Tshikwilimimba** refers to ascites that occurs in old women and is said to be because she had sexual intercourse after her menopause (even if it's with her husband). Ascites in an old man is considered to be bewitchment. Someone has got hold of his urine and put the urine in the gullet of a slaughtered chicken and hung it up somewhere. Apparently the gullet swells and swells and the day it bursts then the old man dies.

- If a young woman of child-bearing age collects dung in the cattle kraal, she will menstruate so heavily that she will die from the blood loss.
(Van Deventer, 1996)

Some cultural 'universals' of South African health beliefs

Several themes or cultural universals run through the health belief systems of South African patients.

Western patients may believe in hormonal imbalances, the correct diet, Margaret Roberts, the local health and racquet club, clean air and the chiropractor. They might even believe in the doctor. Stress is also a major explanatory model in western health beliefs.

In this synopsis some of the universal health beliefs of South Africans with traditional beliefs include:

- Pollution by transgressing cultural taboos. Most of these involve sexual intercourse with a woman who is in a state of ritual impurity such as during menstruation, after abortion or childbirth etc. (This conveniently apportions blame to women and is also seen in the phrase isifo ntombazana which refers to gonorrhea as 'I am suffering from young women'. Nothing seems to have changed since Eve and the serpent).
- Purification or 'Cleansing' is a universal necessary therapeutic manoeuvre both for cultural transgressions and for the removal of poisons.
- Bewitchment or witchcraft as a cause of one's illness or life condition is almost universally thought to be caused by people who are envious or malicious and the cause (mostly unacknowledged and unspoken) is usually do to bad interpersonal relationships at work or in the family or between neighbours etc.
- Sorcery is thought to be carried out by placing poisons in food or inside a woman with whom the man has sexual intercourse.
- The belief of removal of protection of the ancestors is common. Ancestor worship is a misnomer.
- The handling of animal faeces by women of child-bearing age results in serious consequences to health and even death. This is an almost universal cultural belief in South African traditional communities.
- Emetics and purgatives are widely used to remove 'poison' and to treat 'internal anal sores'.

These appear as some of the common health beliefs but two important facets of these beliefs are:

* **Any illness or accident may be ascribed to supernatural forces, however trivial they may seem to the examining doctor.** Even fairly easily explained diseases within the biomedical model such as diabetes or hypertension may be thought to be due to bewitchment, removal of protection by the ancestors or pollution. For instance, some patients who live in Ga-Rankuwa, which is just north of Pretoria, may believe that hypertension in women is due to women delivering in hospital and the doctors and nurses stopping the bleeding with injections. This causes the accumulation of impure blood in the mother's bodies and therefore hypertension. Hypertension is also thought to be infectious and that men get if from women they have sexual intercourse with (Tema & Sebego, 1990).

- **Beliefs may vary markedly from group to group and individual to individual even about a specific causal theory.** Each person you consult has a different opinion or interpretation of umkhondo, umeqo, ukudlula and other health beliefs. The belief of the individual patient in front of you, even if it varies from your beliefs or his or her group's beliefs, is the one which is relevant to him or her. Accepting a patient's health beliefs is one of the essences of the patient-centred approach.

The traditional healer

Witchdoctor is more a lay term that has a wide variety of meanings. Traditional

healer is also a generic term for a wide variety of healers, diviners, herbalists, clairvoyants, mediums, fortune tellers, witches, spiritualists etc.

Nine categories of traditional healers have been proposed (Erasmus, 1992) but broadly speaking there are two major categories:

- The **inyanga** (ixhwele in Xhosa; ngaka in Sotho) who is a herbalist, priest and psychologist and who dispenses umuthi (medicine) and is almost always male.
- The **sangoma** (iqgira in Xhosa) who is a diviner and makes diagnoses and can be female or male although there appears to be a preponderance of woman sangomas.

Some put traditional healers into four categories, which include the two above as well as:

- The **Umthandazi** (muProfiti in Sotho) who are faith healers of the African independent churches and heal by laying on of hands and prayer.
- The **traditional birth attendant** are usually elderly women, who have had children themselves and who act as midwives and give the education and perform rituals associated with pregnancy and birth. *(Abdool Karim et al, 1994)*

A more or less distinct group are the **iqgira** (indigenous healers of the Xhosa) and also the traditional schools of the **sangoma,** who undergo prolonged and intensive training, have a sense of dedication and a calling and who are distinct from herbalists and those who use 'witchcraft', extraction procedures or other techniques. They develop the ability, through training, to sharpen and use an increased perceptual capacity. Their work is similar to that of depth psychologists and they aim to help with resolutions of conflict, give insight to patients, help them regain lost cultural values and help restore a sense of identity, self-esteem and confidence. *(Bührmann, 1980, 1984)*

Zulu sangomas may be divided into three groups depending on the way they work:

- The 'head' or ecstatic diviner **(isangoma sekhanda)** who divines by listening to the ancestors and uses no material objects.
- The 'bone thrower' **(isangoma esichitha amathambo)** who divines from the position and shapes that the bones land in.
- The 'whistling great ancestors' **(abalozi, amakhosi amakhulu)** are those sangomas who communicate with the ancestors, who reply directly by whistling out words from the rafters (possibly by ventriloquism). (Ngubane, 1977, p,102-103)

There are several other types of traditional healers with some specialising in certain fields, eg izinyanga zezulu (who ward off lightning), izinyanga zemvula (who are rain makers).
These definitions and roles varying greatly from province to province and many roles overlap.

The tension between the traditional healer and orthodox medicine

Biomedicine is primarily concerned with the recognition and treatment of disease (curing).

Traditional healers, on the other hand, are more interested in addressing the human experience of sickness.

Healers seek to provide a meaningful explanation of illness and respond to personal, family and community issues surrounding illness.

Three reasons why patients prefer to go to traditional healers are:

- Smaller social class difference between patient and practitioner.
- An increased emphasis on 'explanation'.

- A greater agreement between the explanation given by the healer and the explanatory model held by the patient. *(Kleinman, 1978, 1979)*

The chances of good communication and positive outcomes are increased if the patient has faith in the doctor/healer, positive expectations, health beliefs that fit in with those of the doctor/healer and he or she goes to a client-centred doctor/healer. *(Bührmann, 1979)*

Working together

"We will never become spiritual guide, counsellor, prophet or interpreter of life events like the traditional healer, and we should not feel obliged to replace them". *Dr Ian Couper, KwaNgwanase*

In South Africa, **dual consultations** are common. Patients visit the inyanga/sangoma/igqira/nanga/ngaka and also the western doctor. Broadly speaking the traditional doctor is consulted for supernatural causes and explanation whereas the western doctor is consulted for symptom relief, examination and an injection. *(de Villiers, 1991)*

In fact, the start of the road to the doctor is earlier than the consultation with the traditional healer. These roads to the doctor are called **patterns of resort** and are the paths people make as they pick and choose their way from one sector of the medical system to the other *(Young, 1983)*.

In Nguni culture, the influence of the senior woman of the family (usually the eldest sister of the father's family or the grandmother) is very important. She will usually treat a sick family member in the first instance, often with scarification. If the response is not good, referral to the traditional healer is the next step and only then on to the doctor. It is also important to remember that permission for operation or hospital referral usually has to be given by her, even for adult members of the family *(Daynes, 1996)*.

When a patient attends a traditional healer he is accompanied by a family member not only to report back to the family elders but also because the extended family is included in the treatment. This is why it is important to include family members in the western consultation, which is normally more focused on the individual.

Patients rarely mention to the western doctor that they have already visited a traditional healer.

Factors that influence the decision as to whom to consult include:

access, degree of westernisation, level of education, socio-economic position, influence of relatives, friends and employers and money/fees. *(de Villiers, 1991)*

Another important factor is the reputation of the traditional healer or doctor. If you believe you are going to get better you are half way there. You can 'think' yourself healthy (and you can also think yourself sick).

It has been suggested that there are four approaches that are taken at the interface between modern and traditional medical systems: integration, complementary, rivalry and intercalation.

Integration into the health system has taken place most successfully with traditional birth attendants in several countries.

Complementary refers to services provided by traditional healers as complementing the services provided by the official medical sector.
Rivalry is an antagonistic approach with turf protection.

Intercalation means literally inserting another day into the year (calendar). In this context it means taking traditional medicines/herbs into the orthodox drug list. *(Young, 1983)*.

Some of the downsides concerning cultural beliefs and customs

From the perspective of my medical practice there are certain fairly well known 'side effects' both physical and mental to traditional practices which include:

- Toxic effects of herbal medicines, emetics and purgatives. The toxic effects of the commoner ones have been well written up in the literature. Toxic hepatitis, renal failure and local reactions in the gastrointestinal tract are the commonest side effects. Children with gastroenteritis are very vulnerable to toxic effects of emetics and enemas. *(Watt & Breyer-Brandwijk, 1962; Bodenstein, 1979; Solleder, 1974; Mokhobo, 1976; Buchanan & Cane, 1976; Segal & Ou Tim, 1979; Hutchings & Terblanche, 1989)*
- The collecting of herbs and medicinal plants is now done on such a scale that some species of plants are facing extinction.
- Grief, for instance the death of child, if not properly counselled can result in a father being advised that the death is due to bewitchment. If the person who has putatively done the bewitching is identified (often an elderly mother-in-law) then serious assault or murder is the result.
- Serious illnesses such as AIDS and cancer (in fact, any illness) may have the diagnosis or treatment delayed or may receive inappropriate or conflicting advice.
- Cultural or traditional customs can be misused manipulatively or as excuses or for secondary gain. "Doctor, I drank beer until midnight. About one hour later I started vomiting and realised that this could only be due to poisoning".

Imbiza is a pot, Umuthi is a tree

ImBiza means literally a pot and refers to the earthenware pot that the inyanga mixes his medicines. This is equivalent to the pestle and mortar of the apothecary. IzimBiza therefore refers to mixtures prepared by an inyanga. *(Krige, 1950:329)*

The patient attends the inyanga who makes up the imbiza as a mixture or concoction depending on the patient's problems. The problems arise because the dose is usually 'a handful' (isandla) and this depends on the size of your hand. Men often take the imbiza as an enema for increased sexual performance. This may result in frank haematuria and malignant hypertension due to toxic renal failure. Children with gastroenteritis and who are already dehydrated are also given the enemas on the 'internal anal sores' theory.

Umuthi means a tree and is a generic word used for any medicines such as tablets, antibiotic mixtures etc which are prescribed by a doctor. The original word referred to the bark of trees from which medicines were made. There are also red, white and black medicine (imithi ebomvu, emphlophe and emnyama) that are used for ritual and medicinal purposes.

Amakhambi refer to the green leaved herbs that are gathered by housewives for medicinal purposes and are part of everyday folklore *(Krige, 1950:329)*.

Intelezi is a term applied to a certain group of medicinal plants that are usually kept in a herb patch in the back garden. The word is derived from teleza: to counteract or render innocuous, and they are usually used to protect the home by sprinkling them around the huts or on people (Bodenstein, 1973).

UmBulelo is bad medicine that is place on a pathway by an umthakathi for the purpose of causing fatal disease to those who come in contact with them *(Krige, 1950:331)*.

The sangoma as a patient

Traditional healers never treat themselves or any member of their family in

cases of serious illness. They consult someone else, according to the Zulu saying that "a doctor never doctors himself" **(inyanga ayizelaphi).**

I have treated, in the past, and rather sporadically, two sangomas who came to a rural clinic in the Injasuti valley. I tentatively diagnosed both of them as mild schizophrenia and prescribed a phenothiazine (melleril) on which they appeared to improve (reduced auditory hallucinations in one and improvement in trance like state in the other). These were superficial contacts and they and their families appeared happy with the arrangement. Referral seemed inappropriate in this context as the system that they believed in appeared to be very personal and based on trust.

It has been proposed that **twasa,** being 'called' to be a sangoma, is due to a mild form of schizophrenia. It is difficult to generalise about such a diverse group as sangomas (like is difficult to generalise about general practitioners!).

Diviners who appear to depend on trance like states and visions and mediumship may have different characteristics to herbalists. Some, on the other hand, are tricksters and charlatans.

Sangomas have been described as intelligent, having a well-developed sense of humour, as being friendly and co-operative and often fairly well educated. Some may be extroverted while others have hysterical or neurotic tendencies. Some male diviners have been reported to have a homosexual or a more feminine tendency.

A heightened sensitivity to people and a shrewd appreciation of the dynamics of human relationships appears essential.

Caveat: The hearing of voices that is so much an essential part of our schizophrenic diagnosis is obviously made more difficult with a black patient because of cultural beliefs. The black patient who admits to hearing voices may not be schizophrenic at all but understanding and accepting 'voices' as normal and as a connection with the ancestors. *(Jorsh, 1993; Levinson, 1996; Ingle, 1973; Hammond-Tooke, 1989)*

The non-directive, contemplative GP and the technological, diagnostic GP

"Patients tend to gravitate towards the therapist who shares their world-view" *(Jorsh, 1993)*

It is not possible to generalise about such a mixture of personalities that make up what is termed, the general practitioner, but the two broad divisions above appear to one way of expressing our divergent approaches. Each doctor has his or her own areas of clinical strengths and weaknesses. Acknowledging these is one of the skills of the practice of medicine. One of the important realisations of being a general practitioner is that there are some aspects of general practice that one is just not interested in. Some of us are sangomas and some are surgeons. The important point is to know and come to terms with one's abilities, deficiencies and interests. Patients often seek out the doctor that 'fits' their needs or personality. Some like interventionist technology with firm diagnoses and action while other prefer a slower more natural journey through the consultation. This has advantages and disadvantages.

Those who like the interventionist approach stand the risk of iatrogenesis while those who prefer nature to heal them may be better served by intervention.

Is it possible to be, like Sir Thomas More, a 'man for all seasons'? The ideal is to be both technological competent and patient-centred. Those of us who fall short of this ideal (that's you and me) should try and be aware of and know our own seasons.

A summary of practical guidelines in cross-cultural care

Two of the themes that run like a thread

through this mosaic of cross-cultural interactions are:

1. **We all have cultural ideas which influence us.**
2. **The importance of discovering and understanding the cultural beliefs in the area in which one practices.**

What also emerges from this overview is that a good consultation goes a long way to help the communication and the outcome in all encounters with patients whether they are intercultural or cross-cultural.

What is a 'good' consultation? It is difficult to define and assess. Two of the most important features that we have expounded on in this series are a three stage assessment (individual, clinical and contextual) and patient-centredness.

Some other features are:

- Listening and acceptance.
- There is often, I find, a long rambling story in the oral story tradition. This, you should not stop, unless the noise from the waiting room reaches fortissimo proportions.
- Make use of the patient's and your own non-verbal communication, body language and movements.
- Enquire whether a traditional healer has been consulted and what the recommendations were.
- Understand and accept the patient's frame of reference and keep your explanations within it.
- Explain treatment and diagnostic procedures.
- Make a comprehensive diagnosis in a holistic framework and take into your assessment the patient's cultural beliefs.
- Ask the patient what he or she understands about their condition before your explanations/education.
- Diagnose and treat according to western concepts but explain in the patient's own terms.
- Do not prevent the patient from consulting a traditional healer (unless you enjoy exercises in futility).
- Negotiate with the patient as to what he or she expects to happen.
- Discuss the involvement of the family and communication or involvement of other healers.

Many of these conditions that present as bewitchment or poisoning or possession often have their origins in fairly simple, understandable family conflicts, which are accessible to the general practitioner.

Like ships passing in the night one wonders how many boats one also misses each day.

(References: Wessels, 1985; McWhinney, 1989; and any book on family medicine)

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