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The search for healing and health in Zambian Eastern province: A sociological investigation of imbricated health systems

by

Wilson Bwalya

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Prof. Catherine Burns

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DECLARATION OF OWN WORK

I, **Wilson Bwalya** declare that this Master's thesis/dissertation is my own original work. Where primary or secondary material was used (whether from the internet, printed sources or any other sources) due acknowledgement was given and references were made in accordance with the requirements of the University of Pretoria.

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Signature **Date**

DEDICATION

To my parents, the late Mr W. Mwila and Mrs C.P. Mbola whose discipline and support gave me the grace to become who I am today.

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ABSTRACT

In this study, I investigated the search for health and healing in a region of modern Zambia, tracing the imbricated forms of medical knowledge and practices. Drawing on my completed original Honours research project, and enlarging the number of informants and data collection methods by including some of my new materials in this dissertation, this study sets out to ask new and deeper questions about the sociology of health and healing. Firstly, through published work (from before independence, in 1964 to the 1990s), then through primary material (archival sources; published statistical and census data; medical and public health data etc.); and finally from interviews that I recently conducted.

The study addresses the following objectives: 1. To describe the complex health system of care in Zambia. 2. To describe and analyse the pattern of healthcare seeking behaviour in a complex, inequality and multi-layered healthcare system. 3. To investigate social relations of power, stigma and discrimination in a multi-layered healthcare system. 4. To explore wider considerations of how both men and women in Eastern Zambia perceive, navigate and use different forms of healthcare systems.

This study shows that men and women in this region of Zambia travel a complex journey in search of their well-being necessitated by the inequalities and complexities of regional healthcare systems. The study concludes by showing that the people of this region, demonstrate agency in their health practices, and their health seeking behaviour and actions are adjusted in an effort to facilitate their wellness. Given the gendered and patriarchal context of Zambian culture, the findings of this study are perhaps surprising that birthing women reported male midwives to be more gentle, calm, and respectful than female midwives, and that nurses who work in rural health posts are perceived to be more respectful than the nurses who work at central hospitals, thus these findings may suggest more need to explore these two themes.

Keywords: Imbrication, healthcare, traditional, biomedical, religious

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LIST OF ACRONYMS

CSO	Central Statistical Officer
HP	Health Post
RC	Rural Clinic
TBA	Traditional Birth Attendant
MoH	Ministry of Health
WHO	World Health Organization
UP	University of Pretoria

CHAPTER 1. INTRODUCTION

1.1 Background to the study

It is a truism that in the constant search for well-being, people across the world employ multiple strategies and draw on many resources and forms of knowledge. In communities where healthcare is characterized by inequality; complex structures; historically competing and complex infrastructures and overlapping cultures – what some have called "a plural health system" – people draw on family-based, neo-traditional[1], cosmopolitan[2], traditional[3], commercial, Western and global health and biomedical systems' regimes and medicines (Turner, 1968; Kamat, 2006; Peters, et al. 2008; Digby, 1994; Feierman, 1992; Ngubane, 1977; Samundengu, 1992; Kimani, 1981; Packard, 2016; Flint, 2008; Ncube, 2012; Ferguson, 1999; Burns, 2016; Kalusa, 2007; Chavunduka, 1994 and Vaughan, 1991). In many regions of Southern and Central Africa, this evinces a veritable matrix of health forms, and means that there is no single or mono-approach to healthcare seeking.

In this Masters dissertation, I investigated the search for health and healing in a region of modern Zambia, tracing the imbricated[4] forms of medical knowledge and practices. Firstly, through published work (from before independence, in 1964 to the 1990s), then through primary material (archival sources; published statistical and census data; medical and public health data etc.); and in interviews that I conducted and from recent reports and printed biomedical data.

1.1 *Establishing the historical sociology of healing in Zambia*

As the above cited scholars have established, traditional healthcare system exists side by side with biomedicine. As Kimani argued, the older forms of pre-colonial traditional healthcare systems have endured – albeit with changes and shifts – and are the first layer of a widespread healthcare system in sub-Saharan, Central and Southern Africa, with some widely shared characteristics (Kimani, 1981: 333). The introduction of Western medicines and of

1 Neo-traditional – "Something with elements that are recognizably from the colonial or postcolonial period" (Appaih, 1992).

2 Cosmopolitan – "the connection an urban settler may have with his/her rural homeranges along a continuum – which a rural home village is conceived as primary home to which one is connected more by nostalgia and sentimental attachment than by social and economic ties or life trajectory" (Ferguson, 1992).

3 Traditional – "Something that uses or supposedly use precolonial techniques" (Appiah, 1992). Hosbawm and Ranger (1983: 1), used the "invented tradition" to refer to "a set of practices, that are governed by overtly or tacitly accepted rules and of a ritual or symbolic nature, which seek to inculcate certain values and norms of behaviour by repetition, which automatically implies continuity with the past".

4 Imbricate - means to overlap in a regular pattern (Leonardi, 2008).

systems of scientific medicine in sub-Saharan Africa are all associated with the emergence of settler colonial power; mineral extraction through mining and agriculture; and the coming of the Christian missionaries in the past two hundred years (Spring, 1985: 144; Samundengu, 1992: 27). The missionaries were coming as participants inside of a globally expanding colonial and capitalist system of power, and brought with them their own medicines, medical techniques, and understandings of diseases – still in emergence in the 19th century, and during execution of their duties, they created and supported an uneven medical care service to the local Africans and settlers. (Samundengu, 1992: 28). Later on, as a colonial medical system began to emerge, one of its key characteristics was a form of unequal medical spending and health responsibility which bequeathed to modern Zambia another form of medical pluralism – high functioning often urban health centres and institutional, and a hinterland of much more poorly serviced health entities. After the emergency of era of democracy in Zambia and the liberation of the economy, new forms of capitalization of health emerged – a far cry from medicine peddlers and private General Practitioners, these entities, often with links to other countries in the region, set up private clinics and hospitals that were neither religious nor state run. Lastly, in Zambia today a majority of its citizens are professing Christians. Christianity takes many forms in Zambia, but a core aspect of its body of belief is its healing system. This too exists in a relationship with the other forms of health systems[5] described above.

1.2 *Uneven Expectations of Heath Modernity in Zambia*

This dissertation has shown that there have been periods of key and sharp contrast between traditional, neo-traditional, Western and biomedical healthcare systems in Zambia over the last 50 years. In my previous study (Bwalya, 2018), my informants indicated that they see the power of traditional healthcare as based in supernatural and indigenous knowledge, on apprenticeship-training, as well as on enduring cultural beliefs and practices. Kamani (2008) and other scholars agree that this is in contrast to biomedicine's emphasis on specific replicable interventions, procedures, pharmacology and coordinated curriculum for health personnel (Spring, 1985; Peters et al. 2008). Apart from traditional and Western medicine, this thesis also had to explore religion, because it offers alternative, at times complementary, sources of healing to both traditional and Western means (Mulemi, 2010: 155). In the

5 Health system is defined as "all activities whose primary purpose is to restore, maintain and promote health" (World Health Organization Report, 2000).

religious domain, healing is based on other worldly powers and prayers offered to the patients and congregates, and religious healers claim to treat illnesses through spiritual means (Scott et al. 2014: 296). In this dissertation, I have shown how all these forms of healthcare systems are seen as available options within the landscape of healthcare systems in Africa - Sothern Africa in particular (Dzimiri, et al. 2019; Batisa, 2016; Bene & Darkoh, 2014 and Broom & O'Brien, 2011). They are all part of Zambian and indeed African and global modernity[6].

In most plural and layered health systems, patients seek care from different providers; and these include: those trained in biomedical medicine; those practising forms of traditional medicine; and religious healers (Peters et al. 2008: 166). The existence of any plural or layered health system is an indication that none of the systems adequately meets patients' health needs (Kimani, 1981: 335), because human beings when addressed as, and seeking help as, *patients* have different expectations and health needs as they interact with different healthcare systems (Porter and Porter, 1989). As Spring (1985: 143) and others have shown, in the search for causation of sickness and in the search for health, some choices – however constrained – are made. For example, in Northwest Zambia, people attribute most illnesses to causative agents (unnatural) such as witchcraft and evil spirits; but they also recognize natural causes such as animal vectors; bacteria; malnutrition and stress (Mavhunga, 2018).

In Zambia, just like in many other African countries, new medical ideas and practices were introduced unevenly and with uneven repercussions; in Zambia's case primary by Christian proselyting medical missionaries. In Northwest Zambia, Western medicines was introduced prior to 1900 by Christian missionaries during their exploration work (Samundengu, 1992: 28) and thereafter, the colonial government introduced facility-based clinics; and medical personnel were deployed to run new healthcare systems (Spring, 1985: 144). Later on, the introduction of Christianity to many other parts of Zambia (after World War One), led to the decline of the public practice of certain traditional medicines, largely because these Christian medical missionaries successfully associated such practices with witchcraft and paganism; and urged the eradication or legal circumscribing of these, onto the colonial state structure, which still exist in Zambian postcolonial law to this day (Witchcraft Act of 1914). The whole purpose of this law was to appropriate the indigenous beliefs and knowledge; although minor amendments were made in the postcolonial period (amendments of 1964; 1977; 1993 and 1994), but its original and colonial features still exist (Sugishita, 2009: 441). They also

6 Modernity – "Characteristic intellectual and social formation of industrialized world" (Appiah, 1992). Mbembe used the term "African modernity" with reference to letting go of an essential "Africanness" to dissolve "African into the world." (Balakrishnan, 2017).

succeeded in tying the practice of Christian faith healing to the thwarting of traditional healing. Over the 1920s to 1950s, followers were discouraged from, and even excommunicated from their churches, because such practices were seen as hindrance to their testimony of God (Simundengu, 1992: 34; Kalusa, 2007: 58). As a result, the emergence of Western medicines and Christianity in this African context posed a great challenge to traditional medicines and its practices. This domain of knowledge and practice was not eradicated however, and endures, in different and complex forms, and in relation to private and state biomedicine today; as well as to professions of Christian faith.

Although Western medicine and facility-based healthcare systems were inadequate to cover the entire country – both because they were mainly established where missionaries' activities took place, and where the colonial government's economic interests were vested – Western medicine provided a foundation upon which the post-independence Zambia national healthcare system was built (Simundengu, 1992: vi). However, as Kamwanga *et al* showed, in their Zambian-wide study from the early 1990s, inequalities in the provision of healthcare services continued to be prevalent in Zambia after independence in 1964 (Kamwanga, et al. 1999: 1). The inequalities in public healthcare that exist today are built primarily on an unequal distribution of healthcare facilities between urban and rural areas. At independence, for example, there were only 19 government hospitals, 187 rural health centres for a population of around 3 million, and by 1990 the number increased to 42 hospitals and 661 health centres for a population of around 7 million. As the population continued rising at an average growth rate of 3% per annual; the fertility rate also rising at a rate 7% (CSO, 2014; Zambian Figures from Central Stats. Office 1964-2014), healthcare provision has not been sustained at one level. There are variances regionally and thus these have not had even effects, as the demographic context in Zambia revealed.

The economic boom from copper prices from 1964 to 1975 precipitated the expansion of health sector (Fraser & Larmer, 2010). Health services and many other social services were largely financed by the Zambian government through the profit made out of sale of cooper and social services like health, education were provided free. However, "the economic boom was short-lived because of many factors among them; Zambian mining companies were/have always been price takers in the global market" (Adam & Simpasa, 2010: 59). As Ferguson has shown in his detailed study, following a decline in copper price and a severe debt crisis (Ferguson, 1992: 85), public expenditure towards health sector declined leading to acute shortages of drugs; inadequate manpower and deplorable infrastructure. This situation led to

many people not having access to quality healthcare services and the most affected were women who are the primary seekers of health for their families.

Meanwhile, performance of health indicators such as maternal and child health dropped significantly. For example, by 1992 it was reported that nearly 1 in 5 children died before age of five and from 1977 – 1991, under five mortality rose by 15 percent, from 152 to 191 deaths per 1000 births. Infant mortality rate stood at 107 deaths per 1000 births (CSO, 1992: XV). By 1996, under five and infant mortality rate continued to rise, from 191 in 1992 to 197 deaths per 1000 in 1996 and 107 in 1996 to 197 deaths per 1000 live births respectively. Maternal mortality worsened during the period from 1996 to 2002. In 1996, 649 maternal deaths per 100,000 live births recorded, however the number rose to 729 maternal deaths per 100,000 live births during the period 2001 to 2002 (CSO, 2012: 2).

The change of government through multiparty democracy in 1991 led to health sector reforms (Mwale, 1999:156) that went in tandem with the introduction of Structural Adjustment Programmes (SAP) (Phiri & Ataguba, 2014: 2), which facilitated the introduction of user fees. The stated aim was to improve public financing towards health sector. But as analysis in the early 2000s showed, the repercussions of user fees led to a decline in the use of health services especially among poor people who could not afford (ibid). According to Central Statistics Office (CSO) (2003: 24), 22.1% and 20% of people from rural and urban areas respectively, who visited health facilities between 2001 and 2002 were denied medical care for failure to pay the user fees.

1.3 *Chadiza: uneven and imbricated health choices and practices – a case study*

Situated on a plateau between the Luangwa valley and the great Zambezi river basin, is the small city of Chadiza, made up of just over 70, 000 people. Agricultural production for subsistence is the major source of survival in this region (Bwalya, 2018). The nearest larger city in Eastern Zambia is Chipata, about 80 kms away. This region and its people have felt the sting of austerity policies since the early 1990. Since its creation as a district in 1946, Chadiza has lacked health infrastructure; its first public health facility opened in 1970s.

The introduction of biomedicine and facility-based healthcare in late 1890s in Eastern Zambia is linked to the missionary works of the Dutch Reformed Church of the Orange Free States of South Africa (Cronjè, 1982; Verstraelen-Gilhuis, 1982). The first mission station was opened in 1899 at Magwero near the border of Malawi, followed by Madzimoyo in

1903, Fort Jameson (now Chipata) 1905, Nyanje in 105, Nsadzu in 1908, Hofmer in 1914, Merwe in 1922, Tamanda taken over from Livingstonia mission in 1924, Kamoto in 1928 and Katete in 1944 (ibid.).

For the purpose of this study, I am interested in exploring the introduction of biomedicine and facility-based healthcare at Nsadzu, which is part of Chadiza district from 1908 onwards. The establishment of a Dutch Reformed Church mission station at Nsadzu came with the establishment of biomedical healthcare systems, education, agricultural and industrial work, just like in any other Reformed Church mission stations (Cronjè, 1982). Later on, the Catholics also arrived and established their mission station at Naviruri, a few kilometres away from Nsadzu. However, historical records show how the people of Chadiza resisted and showed antagonism towards the new and unknown Christian religion, including their education and healthcare systems (ibid.). They only succeeded by using trained local auxiliaries and through attractions – curing the sick using Western medicines and providing employment to the local Africans, and introduction of new agriculture techniques were some of the strategies used (Groeneveld, 1994; Verstraelen-Gilhuis, 1982; Cronjè, 1982). The subsequent colonialization and establishment of colonial state led to financial assistance given to Christian mission stations for the education, agriculture and medical works (Verstraelen-Gilhuis, 1982). These Christian missionaries introduced a racialized and class-based medical care system. As Verstraelen-Gilhuis, shows that at Madzimoyo mission station, west of Chadiza, three hospitals existed, one for Africans, another for the Indians and the other hospital for Whites. This was in line with the pattern of social segregation in colonial societies (ibid.: 137). Specialized form of education, though gendered, was introduced for the girls. Girls who attended missionary schools were trained in homecraft, first aid, hygiene, among other trainings (Cronjè, 1982). Training in homecraft and other informal activities were not good option for girls and women, as it was/is difficult to make a living out of such informal skills. The gendered training of girls by missionaries was not peculiar to Zambia. This was also observed in Zimbambwe among other countries (Batisai, 2013; Hungwe, 2006).

The Christian medical missionaries also introduced a gendered healthcare system (Cronjè, 1982), as majority of the people who were providing nursing services and teaching African domestic work were wives to male missionaries, as the case of Mrs. F. van Eedem, wife of mission father at Magwero mission of the Reformed Church, the first mission church to introduce biomedicine in Eastern Zambia (ibid.; Verstraelen-Gilhuis, 1982). These early

Christian missionary medical work presents striking feminine images and entrenched patriarchal culture given the gendered division of labour within their activities. In addition, they also marginalized, stigmatized and isolated people who suffered from certain diseases from the rest of the communities. For example, the outbreak of leprosy in Eastern Zambia after the first World war, led to the establishment of Leprosarium at Nsadzu mission in 1930, and isolation centre (today known as Jack village in Chadiza) where people who were treated with leprosy were resettled away from their original villages (Cronjè, 1982).

As discussed earlier, Christian medical practices was also conducted to the thwarting of various African traditional beliefs, for instance the case of *Chinamwali* (puberty) ceremony of the Chewa people of Eastern Zambia which was later on replaced by a developed Christian initiation version called *Chilangizo* (meaning instructions) for mature girls which was conducted at Reformed church lay training centre under the instructions of missionary instructors (Groeneveld, 1994; Verstraelen-Gilhuis, 1982). These Christian missionaries and colonial state imposed Western systems and undermined indigenous belief systems, without understanding the values and made no attempt to determine the validity of African healing and religious systems. So many tactics and different methods were used, as this section illustrates as well as other scholars such as Chavunduka (1994: 6) who pointed out that "Christian education was/is regarded as one way of weakening traditional beliefs and practices." However, today both the *Chinamwali* and *Chilangizo* exist and young people participate in both ceremonies.

Review of various historical records also shows how the coming of Christian medical missionaries and later on colonialists, Westernised many Zambian people (Taylor & Lehmann, 1966; Turner, 1968; Groeneveld, 1994; Verstraelen-Gilhuis, 1982). In his study of the Ndembu people of Northwestern Zambia, Turner (1968) observed that Ndembu people managed to preserve many features of their traditional healing and religious system because they were by then, the least westernised and most isolated Zambians. During the time of contact with Christian missionaries and other Europeans, Africans were rapidly losing their traditional belief systems and becoming more Europeanized (ibid.).

Therefore, it is important to examine the social relations of power as they unfold in healthcare systems linked to stigma, discrimination, coercion, conflicts and isolations of certain medical knowledge and healing systems.

Key points from the contextual evidence

To begin with, an insight into Christian medical missionary records, published and primary literature about healthcare systems in Zambia – traditional, biomedical, religious healing and its providers demonstrate imbricated forms of medical knowledge and practices as there is overlapping of knowledge, techniques and practices (Kalusa, 2014; Spring, 1985). However, it was within the first Christian medical missionaries' work and compassion for the sick that medical services were provided, and extended to the people who had no access to Western healthcare systems, way before the establishment of government healthcare system (Cronjè, 1982). It was also within their Christian practices that caring for the sick was part of their Christian outreach (ibid.).

A review of historical and anthropological work also shows the co-existence of traditional and Western medicine (Turner, 1969; Kalusa, 2007; 2014; Spring, 1985; Groeneveld, 1994) and patients sought care across various health systems and healthcare practitioners, equally integrate certain elements and practices of other health systems. This was not unique in the Zambian context, as many examples can be drawn from other countries in Southern Africa like Zimbabwe (Chavunduka, 19940; Mavhunga, 2018), South Africa (Flint, 2008; Ncube, 2012), Kenya (Kimani, 1981) and so on. Given this evidence, it can be argued that in a plural healthcare system, people recognise and draw from various medical knowledge and systems. This is because scientific, traditional and religious systems or any other forms of medical knowledge, methods and practices, though competing, are used concomitantly and for the same purpose.

The purpose of this dissertation

Drawing on a completed original research project (Bwalya, 2018), and enlarging the number of informants and data collection methods, this thesis set out to ask new and deeper questions about the sociology of health and wellness in this region. My hypothesis was that as the precarity of the postcolonial and post Structural Adjustment era became more visible, so women and men in this region adjusted their wellness practices and health seeking actions – including around issues of childbearing; contraception; sexual and reproductive health – to embrace enduring; reinvented; as well as new faith-based forms of healing, at the same time as they pressed for biomedical state services. Describing and analysing these complex systems of health is the heart of this thesis.

1.4 Statement of the problem

With the shifting political and economic context that I have laid out above in mind, and based also on their own evidence of deteriorating health conditions, including in Eastern Zambia, the Zambian government abolished user fees at all primary healthcare facilities in 2007 (Phiri and Ataguba, 2014: 2), resulting in some improved health indicators and better access to primary healthcare services. However, Ngoma, in a 2016 study, reported unexpected underutilization of some of health services provided. The causes for this decline in uptake of healthcare services remain a puzzle. Meanwhile, it is estimated that "80 percent of Zambian population use traditional and alternative services for their day-to-day healthcare" (Ministry of Health (MoH), 2012: 12). I believe there is a link between these two known facts.

Like many African countries and even developed parts of the north, inequalities and complex and historically competing forms of health systems (plural and also multi-layered), characterize the Zambian health systems. As people navigate these complex and layered health systems, their pattern of healthcare seeking changes (Scott, 2013), in an effort to facilitate health and healing. As reported by Spring (1985), Kalusa (2007) and by work I conducted last year, in Northwest Zambia, people employ multiple and non-directional routes in pursuing available options for the treatment of illnesses. This was especially true for pregnant women (Bwalya, 2018) who perceived mixing biomedicine, traditional medicines and religious healing as an effective way of treating certain ailments. The use of mixed healthcare systems among women, pregnant women and those who treat fertility issues, has been observed in other Southern African countries, for example Zimbabwe and South Africa (Batisai, 2016). Although, several studies (for example, Scott et al. 2014; Peters et al. 2008; Kamat, 2006; Kamani, 1981 and Mulemi, 2010) have shown how some of these key economic and political factors linked to care seeking in plural health systems, very little is yet known about the power dynamics that exist in these health systems – that I wish to address.

1.5 Research Questions

The main research questions for this study are: What are the wider considerations made by both men and women as they seek healthcare in the Eastern region of Zambia? In the mixture of these considerations, how do gender, class and age reproduce in complex, multi-layered and historically competing healthcare systems?

1.6 Aim and Objectives of the study

Broad objective:

The broad objective of the study is to investigate the social relations of power, stigma, and discrimination linked to gender, class, age and other forms of inequalities in healthcare provisions and the agency of Zambian people in seeking health.

Specific objectives:

1. To describe the complex health system of care in Zambia.
2. To describe and analyse the pattern of healthcare seeking behaviour in a complex, inequality and multi-layered healthcare system.
3. To investigate social relations of power, stigma and discrimination in a multi-layered healthcare system.
4. To explore wider considerations of how both men and women in Eastern Zambia perceive, navigate and use different forms of healthcare systems.

1.7 Rationale of the study

While the study conducted by Spring (1985) and Turner (1968) on how people of Northwest Zambia participate in both traditional and Western healthcare systems, their findings are outdated given the emergence of new data on health in the region; furthermore, they are concentrated in one region, therefore cannot be generalized to the rest of the country. Again, the study by Sugishita from 2009, based in Lusaka alone, cannot also be generalized to rural areas, particularly rural parts of Eastern province of Zambia where majority of the people are marginalized and have no access to primary healthcare services.

Taking into account of all of this, and these lacunae, and drawing on the emerging sociology of health literature in the post 2010 era – which speaks to debates about the post colony; infrastructure of modernity; and imbricated medical systems – this thesis aims to contribute by generating literature to fill up that gap.

This study also gives a voice to marginalized women in particular, because they are the primary seekers of health for their families and are marginalised in public life, as it will document their narratives and experiences as they search for their wellbeing.

Growing evidence suggests significant interpenetration and overlapping of certain elements between traditional and biomedical practices, and patients too, seek care across different health systems (Bwalya, 2018). However, health policy interventions in Zambia have not taken into account this imbrication. Therefore, this study endeavours to generate new and detailed information that can help policy makers, health planners to develop regulatory framework that would recognize different forms of healthcare systems and challenges current flimsy standards, often based on little research, for service provisions for people who use different forms of health systems.

1.8 Structure of the dissertation

The structure of this dissertation is as follows; Chapter 1 gives the background of the study. It also illustrates the emergence of different forms healthcare systems in Southern Africa, particularly Zambia. The chapter also demonstrates the hegemonic practices of biomedical systems to the thwarting of other forms of health and healing, such as traditional beliefs and healing systems. The chapter concludes by showing the resistance, persistence of traditional belief and healing systems and the agency of the people of Eastern Zambia, before, during and post-colonial era.

Chapter 2 shows the extent to which current literature on medicine in Southern, Eastern and Central Africa have taken the form of division between traditional and Western medicine. However, this chapter also draws on various scholarly works to demonstrate the complexity of modernity of technological advancement, of state policies, economic and politics and new patterns of health seeking behaviour by people across the globe. The chapter also discusses the social construction theory which has been largely used in the field of sociology of health and illness to illustrate how medicine emerge has a form of culture, knowledge and social institution and the interplay of power dynamics.

Chapter 3 discusses the research methodology used in this study. The chapter begins by discussing the research design, study settings and participants, sampling strategy, data sources, data collection methods and analysis. The chapter concludes by discussing the ethical considerations. Finally, chapters 4 and 5 discuss the key research findings as well as chapter 6 that also summarises the study findings, and gives recommendations.

CHAPTER 2. REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

2.0 Introduction

This literature review largely demonstrates the extent to which current literature on medicine in Southern, Eastern and Central Africa has taken the form of division between traditional and Western medicine. These are the key points in the current literature about medicine in Africa. However, my thesis has pushed beyond this point by drawing on scholarly works on the complexity of modernity of technological advancement, of state policies, economic and politics and new patterns of health seeking behaviour by people across the globe.

In this dissertation, I build on the work that I did in my Honours research project by researching the complexity of health systems in the region of Eastern Zambia. Like many countries in the world, women and men in Zambia travel a complex journey in search of their well-being in a country that is characterized by health system that is not only plural but also complex and multi-layered system that offers health opportunities, health impoverishment, health materiality and ideology and health culture. Some of these healthcare systems are still using pre-colonial techniques, some of the health practices have been abandoned, while some have been re-invented into neo-traditional and some are part of the global health movement like the Chinese and Indian origin medicine. This allows us to question some of the assumptions of the neat divisions between modernity and tradition, Western and traditional medicine; and a more complex and challenging picture emerges where human beings in search for health and healing, are involved in a multi-layered, complex health systems with many areas of choices and many limitations.

Therefore, sociology becomes an ideal discipline to pursue this research agenda because it is theoretically sophisticated; it looks at the patterns in human behaviour; it also examines the power relations and questions some of the widely held views and assumptions about certain phenomenon.

2.1 What is already known

Many scholars across various disciplines such as sociology, anthropology and historians have written about medicine in Africa, particularly Southern, Central and Eastern Africa. Some of the notable influential scholars such as Chavunduka, 1994; Vaughan, 1991; Flint, 2008; Kimani, 1981; Digby, 1994; Feierman and Janzen, 1992; Ngubane, 1977; Packard, 2016; Ncube, 2012; and other scholars such as Spring, 1985, Kalusa, 2007 and Sugishita, 2009 have

also written about traditional medicine, Christian medical missionaries and the introduction of Western medicines in Zambia. In this literature review, I will be regularly engaging the works of these scholars and many more who have written about medicine in Africa.

As early stated, in many parts of Southern Africa, Western medicine was introduced by Christian medical missionaries, who as well practised Christian faith healing (Feierman & Janzen, 1992). Although Christianity presented itself as another system of health and healing (Mulemi, 2010; Simundengu, 1992; Spring, 1985), the introduction of Christianity and its Western medicines contributed to the rise of imperial powers (Kalusa, 2007). As Camody (2002) points that, in an expanded European imperialism, trade and commerce, many religious leaders (particularly White Fathers) facilitated foreign companies like the British South African Company (B.S.A.C) to gain access to tribal land (for instance, Bemba land in today's Zambia). Therefore, we cannot underestimate the powers of Western medicines in an expanded colonial and capitalist imperial system that lasted for over two hundred years. The manner in which Christianity was introduced as a new system of health and healing by the Christian medical missionaries and received by the local Africans explains the colonial power relations, identity, defining and understanding diseases; and at the same time, undermining the local African's ability to define, interpret and treat diseases (Kalusa, 2007; Samudengu, 1992).

However, not everything was received on a silver-platter, because the introduction of biomedicines in Africa met with some resistance that led to the decision by Christian medical missionaries to start training local medical auxiliary agents who could help them translate and convince locals to accept biomedicines (Kalusa, 2007; Ncube, 2012). This is because when Western medicine was introduced in most parts of Africa, it came as both a strange and competitor to already established means of diagnosing, curing and seeking help for sickness (Zeichner, 1988). As Ncube observes, Western medicine became a powerful hegemonic force that undermined indigenous knowledge about diseases, health practices and African traditional religion while encouraging the use of Western medicines and advancing Christianity (Ncube, 2012: 815). Historians have shown that Western medicine was one of the strategies used by Christian medical missionaries to attract and convert Africans into their Christianity. Scholars such as Ncube (2012), Kalusa (2007) and Flint (2008) establish the hegemonic practices of Western medicines over folk or traditional medicines, and these practices were intended to suppress the indigenous knowledge of understanding, interpreting and treating diseases, through their crusade and labelling of traditional medical practices as

"paganism," primitive, backward and unscientific. The introduction of Western medicines ignited conflicts and compromise as both Africans and Westerners showed discordant attitudes towards each other's medicines and more so both of them wanted to advance their medicines and therapeutic methods (Ncube, 2012). Therefore, healthcare systems that existed in both pre-colonial and colonial era became sites for conflicting interests; brought Africans and colonial settlers into negotiations, compromise and accommodations (Ncube, 2012).

With the coming of colonial government and European settlers, and the influence of Christian medical missionaries, legal frameworks on medical practices were introduced in almost all colonies to ensure that traditional medicines and its practices were policed and hopefully eradicated (Flint, 2008; Chavunduka, 1994 and Sugishita, 2009). In Zambia, for instance, the Witchcraft Act of the 1914 retains its colonial features in the current constitution (Sugishita, 2009); and in today's South Africa, the Natal Native Code of 1891 was enacted to ensure that folk medicines and its practitioners were policed (Flint, 2008). It is through these legal frameworks that traditional medicine or indigenous knowledge systems circumscribed and distanced from other domain of healthcare systems (Flint, 2008). Other tactics such as building of hospitals and schools were used to break down and weaken traditional health belief systems and its practices (Chavunduka, 1994). Despite all these tactics, legal frameworks, and other measures that many governments and Christian missionaries had put in place, Chavunduka (1994: 10) observes that the persistence of folk medicine is as a result of failure of biomedicine to get good results or even better over certain diseases.

Traditional and Western healthcare systems are intertwined. Traditional medicine has been an alternative and complementary therapeutic means to biomedicine. In the present days, in many societies across the globe, traditional medicines such as Chinese or Indian or some local herbal remedies have found a place in modern pharmaceutical outlets and practices (Flint, 2008; Ernst, 2002). In a pluralistic health system, there are widely shared characteristics and techniques between traditional and biomedical practices (Chavunduka, 1994; Spring, 1985). In Northwest Zambia, for instance, Spring (1985) observes that traditional healers integrated biomedical practices; traditional birth attendants also incorporated some massaging and breathing techniques. Similarly, traditional healers discovered some of the medicines such as cascara, opium, joinquinine, digitalis and others that are now incorporated in biomedicines (Chavunduka, 1994: 9). In addition, the Europeans' encounter with diseases in Africa, which they had no knowledge of, made them to adopt and use African medicines and its practices – hence serving their lives (Flint, 2008).

This approach to health and healing demonstrate the dialectical aspect of traditional and biomedical healthcare systems. Therefore, the argument by Kimani (1981) that traditional health system is static cannot be proven but instead it has been dynamic and continuously changing through interacting with other forms of health systems (Flint, 2008). In view of the forgoing, I can argue that in a pluralistic and multi-layered health system, exchange of ideas, knowledge and techniques do exist.

In today's African countries, the negative connotation about African medicines has not been eradicated in some parts due to the maintenance of colonial structures, such as laws against traditional practices and he widespread demonising of traditional religion in some Christian formations. The traditional healthcare system has been least understood and accepted, and always subjected to strict policing. For example, many governments, organizations, individuals and some scholars attribute the causes of increased maternal mortalities and pregnant-related complications to the use of traditional herbal medicines (Rasch, et al. 2014; WHO, 2002). In Ghana, for instance, it was alleged that people were dying because of their preference to use of traditional medicine rather than Western medicine (Appiah, 1992). However, scholars such as Appiah (1992: 104) criticises such views and labelled them as, not only backward but also tragic.

2.2 *Healthcare systems as "imbrication"*

An insight into literature demonstrate imbricated forms of medical knowledge and practices as there is interpenetration, interchanging and overlapping of knowledge, techniques and practices (Flint, 2008; Chavunduka, 1994; Spring, 1985). Studies across disciplines demonstrate significant imbrication of health systems in which practitioners across various forms of healthcare embrace and incorporate elements of other health caring system to meet patient's health needs. Studies also show that patients seek care across various health systems and healthcare practitioners, equally integrate certain elements and practices of other health systems (Chavunduka, 1994; Spring, 1985). This challenges the dominion, isolation and universal claim of certain knowledge (Burns, 2016), such as the scientific and rational claim of medical knowledge and its practices. As Burns (2016: 80) further points out that "the structures of knowledge are imbricated with marks and forms of vanquished and the oppressed." Therefore, using imbrication as a metaphor provides a new lens for understanding of the intertwined and interconnected structures that seems to be isolated but forms an absolute matrix structure. In this case, the imbrication of health systems, as

Beckfield et al. (2015) points out blurs the boundaries and evoke transformation; giving rise to new complex forms of veritable matrix of healthcare systems. In this study, I can therefore, conceptualize imbrication as the overlapping of different health systems to support, promote and maintain wellbeing of the people.

The imbrication of health systems induces changes in individual's patterned health seeking behaviour and experiences as they navigate different forms of health systems in search for wellbeing. Informed by Leonardi's imbrication perspective in which the material and social agencies intersect and support one another resulting in changes in individual's patterns of interaction (Leonardi, 2008), the interaction of different health systems coupled with socioeconomic and cultural context determine patterns of interaction (Stamatin, 2012). It is inevitable that when a group of people interact with the environment, new complex systems, structures, behavioural pattern and relationships emerge, hierarchies, rules and intangible elements such as culture and beliefs are formed (Cordon, 2013: 14). This shows that healthcare systems are open systems (WHO, 2000), influenced by inside and outside factors but at the same time they have the ability to adapt, change and respond to any occurrences in order for them to survive and endure over time. For example, traditional healthcare systems has been bequeathed and vanquished by modern healthcare practices but at the same time, it has survived, re-invented into neo-traditional and remain persistent.

2.3 *Gender, age and experiences of health caring*

Health opportunities and inequalities are at the intersection of multiple factors of vulnerability such as, gender, age, class, sexual orientation, citizenship, among other factors (Yuan, 2007; Gazard, et al., 2018; Jewkes, et al. 1998). In developed countries, health inequalities lie mainly at the intersection of social status and citizenship (for example, migrant status) (Gazard, et al., 2018). Meanwhile, in developing countries, the socioeconomic status strongly dictates the type of healthcare services people use (Kabwe, 2008). Age and social class are also other determinant factors (Phiri & Ataguba, 2014). As the study by Mathole et al. observes that the age, parity and women's experiences with healthcare systems influence the use of certain healthcare services. From the biomedical point of view, a woman's old age and parity make her to be classified as high risk (Mathole, et al. 2004), but this also comes with embarrassment, discrimination and stigma as they seek care especially during pregnancy. It is through such obstetric experiences that many women feel more

comfortable with healthcare providers of their own gender, culture and social class (Zeichner, 1988).

Studies on the use of healthcare systems and treatment, report gender differences (Rohde et al., 2014; Mathole et al. 2004; Kabwe, 2008). It is believed that women visit and use healthcare services more often than men use. In religious healing systems, women visit and seek help from religious healers more than men do (Kabwe, 2008). Women's primary role in family caring associated with motherhood (Mkhwanazi et al., 2018), explains the reasons women frequently visit healthcare facilities. As Alvesson and Due Billing (1997), points that caring for the family members and housework fall within women's duties as prescribed by patriarchal societies. This also elaborates gender roles that make women's experiences of motherhood and caring for children different from men, thus making a maker and contributing to men and women seen and treated differently from one another. In this way, caring work can be explained in terms of "gender division of labour" (Connell, 2005: 74), in which men and women are involved in different tasks, for example the social reproduction surrounding caring work is gendered and care is seen as a woman's arena (Nilsson & Larsson, 2005).

Although, there are other determinant factors linked to care seeking such as location, costs, quality of healthcare services, healthcare seeking strategies are determined by various factors including previous experiences and interactions between the provider and the patient (Scott, et al., 2014). Men and women are involved in everyday life social interactions that do not only happen at micro-level but also at macro-level whereby social institutions regulate and normalise the practices of gender (Radtke & Stam, 1994; Bottorff, et al., 2011). At the macro level, the influence of institutions shape people's experiences and inescapably affect ways in which they organize their interactions (Bottorff, et al., 2011). In health institutions for example, the patient/provider social interaction explains the power relations based on gender or class position that influence patient care decision-making and can affect health outcome (Mulemi, 2010). This also entails focusing on institutions as arenas in which gender is produced. As Fausto-sterling (2000) observes that social institutions perpetuate gender inequalities through enactment of differences between men and women. Radtke and Stam also explain the connection between gender and power, and argues that gender is socially constructed through practices of power (Radtke and Stam, 1994). Thus, power relations under-gird the enduring inequalities between men and women, and men are inevitably seen to

be more powerful than women; (Connell, 2005), with some exception for senior older women (as the later chapters show).

Growing evidence suggests how patriarchal societies construct different forms of domination and oppression through social interaction. For instance, West and Zimmerman (1987: 129) explain how gender is performed and argued state that "gender is not a set of personal traits but a by-product of social doing." West and Zimmerman's argument focuses on human social interaction or actions responsible for producing the meaning of gender, and social arrangement that validates division in society (West & Zimmerman, 1987). It is through social interaction that gender is constructed as a manifestation of *femaleness* and *maleness*. Through stereotyped roles, such women's reproduction and caring roles for the family -- which are largely socioculturally determined – individuals tend to theorize masculinity and femininity as socially determined environment (Nilsson & Larsson, 2005). In this way, gender is constructed by way of people interacting with their social environment, which too, enables them to understand the social world around them (Butler, 1988; 1993; de Lauretis, 1987; Ratele, 2014; de Beauvoir, 1986). These concepts (feminine and masculine) are also seen as contrasting, hierarchically ordered, and where masculinity dominates femininity. Thus, as in patriarchal societies gender shaped not only women's roles but also masculinity (Connell, 2005: 71; Bottorff, et al., 2011).

It was not only in African societies that gender was seen as a more of "less given" category in every day thought. In early Western discourses as well, gender was treated as something static and emphasis placed on gender as sex (de Lauretis, 1987). However in the past several decades of gender research, the concept of gender has been raced through time and we now see that in every society it is visibly dynamic, and its socially constructed roots are more visible than hitherto understood (Butler, 1993). Unlike sex, which is biologically determined, gender is socially constructed, although it is seen as and also "absorbs and displaces sex" (Butler, 1993: 5). In this way, gender takes the position of sex that results in ensemble of social relations (Haug, 2002), which historically constructed gender as women and men based on sex roles. According to de Lauretis, in Western discourse, gender was seen as sex differences that paradoxically puts women as reflections of masculine desire (de Lauretis, 1987: 1 -2). Additionally, in order to understand the complexity, dynamism and diversity of gender, contemporary feminists analyse gender intersectionally to include other factors such race, class, age, ethnicity and sexuality (Andersen & Collins, 2010).

Nevertheless, using Connell (2005) theory of gender relation that explains femininity and masculinity at macro-level – whereby different and diverse social structures shape and influence dominant experience of men and subordination of women – this study shows that gender relations are made through operations of power such as decision-making around health – life and death decisions. Because of unequal relationship between men and women, gender relation become a central regulating mechanism in all social formations, be it economic, political, religion, law, sexuality, labour division, morals, bodies and so on, (Haug, 2002). Furthermore, by looking at hegemonic masculinity practices in patriarchal societies, Connell (2005) argues that there is gender hierarchy, in which social practices of masculinity subordinates femininity. It is through gender orders that men assume more powers that result in domination of women.

Gender theorists such as Connell (2005), Rabe (2014) and Jewkes, et al. (1998) also show that in domains with very clear gender outcomes (such as childbirth and reproductive health), the gender power operation is even more marked. Scholars such as Butler identifies heterosexual desires based on reproduction as one way in which femininity and masculinity unite in a hierarchical and binary relationship (Butler, 1988). The power relations between men and women emanate from everyday social interactions and practices in which maleness and femaleness are produced and reproduced (Connell, 2005). It is undeniable that relations of power lead to certain ways of organizing societies. As Radtke and Stam (1994) establish, this everyday social interaction can also take place at institutional level whereby gender practices are regulated and controlled, as the case in health institutions where gender is policed (Rohde et al., 2014; Mathole et al. 2004). Thus, this literature establishes the gender hierarchies, inequalities and social relations of power. In this study therefore, gender is used as a socially constructed concept to mark the differences between women and men based on their sexed bodies, which results in gender hierarchies, inequalities and social relations of power.

2.4 *Social class and experiences of healthcare*

Unlike other healthcare systems, the biomedical system is characterized by inter-professional relationships based on a hierarchical model and built around specialties and professional stereotypes (Molina-Mula, 2018). For example, a nursing career is highly feminized, leading to remarkably low numbers of male nurses. Burns (1998: 695) acknowledges the existence of male nurses in South African healthcare system as early as 1900s, and states that “the

existence of male nurses, especially black male nurses, was a challenge to the gendered and racial hierarchy of health services, an aspect of South Africa's health and medical history that has gone largely unnoticed." Although health caring is highly dominated by females, the gendering of professional work shapes career choices, hierarchies and specialities, which in turn socially construct professional experiences of both male and female health workers, and limiting opportunities for institutional positions of power, authority and influence (Chroroszewicz & Adams, 2019).

In terms of inter-professional relationships, in biomedical healthcare system, an assistant nurse depends on a nurse, who in turn depends on the doctor as an expert, who at the same time occupies highest position in the chain of command (Molina-Mula, 2018). Thus, clinical practices and established relationship between the patient, family members and the care provider is largely dependent on this line of command and influence of inter-profession relationship. A study conducted in Kenya by Mulemi (2008), found, in terms of social and medical hierarchy within hospital set up, that the lower position occupied by patients affect their capacity to negotiate their care. Therefore, patients' lower medical hierarchy and sometimes their lower social status make them depend on medical staffs' decision-making and places them in a subordinate roles in relation to medical staff (ibid. : 124). Patients perceive the hospital environment and its treatment practices as the processes in which they are required to accept and follow instructions and abide obedient roles whenever they interact with medical personnel. In this way, any action by the patient that seems to be upsetting their care provider means a risk toward their life (ibid.).

This social class struggle in the hospital environment and treatment process does not only affect patients but also affect medical staff. Jewkes et al. (1998), in a large study about the reasons why nurse abuse the patients, found that " nurses engage in a continuous struggle to assert their professional and middle class identity and in the process deploy violence against patients as a means of creating social distance and maintain fantasies of identity and power." Thus, the use of violence against patients becomes one way in which medical personnel reassert and claim their class status and command respect from the patients. Hence, this constant class and power struggle in which health personnel are embroiled "creates social distance, show lack of compassion and ultimately lead to physical violence" (Jewkes et al., 1998: 1793).

Depending on gender, sexual identity, socioeconomic and other determinant factors, in a society characterized by pluralistic healthcare system, different health opportunities and many areas of choices are available, which in turn influence people's health experiences and healthcare seeking behaviour (Bottorff, et al., 2011). As Currer and Stacey (1993) point out , in a plural healing system, people have choices even in a limited way – the way that they conceptualize illness' which healer to believe in; and which health system to seek help from and in what order.

As discussed earlier, class position though economically determined, and gender and any other form of domination, are products of human interaction and of everyday social life. For example, both men and women construct and express masculinity and femininity in their social interaction. Thus, stereotypical gender identities are constructed (Holmes, 1997). In the part of Zambia where this study was undertaken, relatively little has been written about how people "do gender," "enact class differences" and how other forms of inequalities manifest, but a key site in this study is around health and the body and this thesis is attuned to evidence of the making and unmaking of gender norms and possibilities in the search for healing and health.

2.5 Theoretical Framework

Social Constructionism

Grounded in the theoretical foundation as illuminated in the social construction theory (Berger & Luckmann, 1966), the basic assumption of the theory is that the world is constituted by several and competing forms of knowledge and reality, and that there is always one form of knowledge that presents itself as ultimate superior to other knowledges. As people interact in their everyday social life, their way of understanding the surrounding world is socially constructed. Berger and Luckmann point to the challenge of competing forms of knowledge and truth, and argues that the increased economic surplus and division of labour give rise to expert knowledge (Berger & Luckmann, 1966: 102). The expert knowledge claims dominant position and becomes the main dominion of knowledge over other forms of knowledge. In this way, social constructionism tends to question the claims to the existence of essential truths (Lupton, 2003).

In every social interaction, individuals portray themselves and their version of story as ultimate truth and always want their version of reality to prevail over other versions. Social

constructionist have argued that what is seen to be truth, is actually the product of social relations of power, hence not neutral but always acting in the interests of dominant groups (ibid.). Since all kinds of knowledge are created through individuals participating in the social relations in which social construction of reality occur, knowledge itself cannot be independent and cannot be seen as universal. Andrew (2012) observed that in the social construction of reality, the dominant individuals or groups' version of truth prevails over the other. This is evident for example, in biomedical reality that exclusively takes control of the understanding, interpretation of illness and patient's experiences, hence enjoying the dominant position. A study conducted by Mathole et al. (2004) reveals biomedical knowledge and its practices, enjoy privilege status and tend to ignore the knowledge and health experiences of patients.

In social construction theory, the world is experienced as both subjective and objective reality (Berger & Luckmann, 1966). The world as an objective reality is better understood in terms of people's interaction with their social environment, which in turn influence them to engage in habituated and routinized activities. This entails that any frequently repeated human actions result in behavioural patterns that is reproduced without much effort (Berger & Luckmann, 1966). In addition, the world is also experienced as subjective reality through the process of socialization that assign people's identity and give them specific places in the world based on their purported identity (Berger & Luckmann, 1966).

In all these processes, language is the most important medium for socialization (Berger & Luckmann, 1966). In social constructionism, "social life and social norms are fundamentally shaped and constructed by language, discursive frames and interpretative histories" (Chadwick, 2018: 7). Thus, language precedes concepts and provides the means by which the world is experienced (Andrews, 2012). Language becomes paramount for constructing the meaning, categories and representation. For example, the use of language by both women and men indicates gender boundaries and expression of femaleness and maleness in the social construction of gender (Holmes, 1997). As a result, language functions as a gender identity maker. Scholars such as Michel Foucault demonstrated how language is used as a tool for exerting power and for construction of identity (Foucault, 1978). The use of language to cultivate and structure relationships also explains the fundamental links between power, identity (for instance, gender, class) and knowledge. Thus, power is maintained through the language or discourse production, in which propagation of knowledge and power itself, are upheld. Since language is taken as a social practice, the power of text or discourse is realized

in the depiction of identity, ideology, and culture and gender representation (Kanwal & Garcia, 2019). As Foucault (1978) argues, by using the language, people do not only express their realities but also exert power and construct their identities through language. Foucault's historical accounts provide usual insights into power and bio-power in contexts outside of Europe as well, as will be draw on in this study.

The application of social construction theory in the field of sociology of health and illness is largely based on the "examination of social aspects of medicines, the development of medico-scientific and lay medical knowledge and practices" (Lupton, 2003: 12). Lupton further argues that "the theory does not question the reality of illness or bodily experiences but merely emphasizes that such experiences are known and therefore, can be interpreted through social activity, and can also be examined by means of cultural and social analysis" (ibid.). This theory "regards medical knowledge not as incremental progression towards a more refined and better knowledge, but as a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated" (ibid: 12 – 13). This approach by social constructionists calls upon alternative ways of understanding and looking at biomedical claims of reality as social products, just like lay person's knowledge of medicines be it traditional or biomedicine.

According to Lupton (2003: 13), the ways in which the medical and scientific knowledges have been used and positioned as dominant knowledge of the powerful groups to the detriment of other knowledges, has elicited feminists interests. Some notable contemporary feminist scholars who have come to question the processes of knowledge production and validation, which they argued, is not neutral, are Haraway (1988), Collins (2000) and Narayan (2004). These feminist theorists have argued that knowledge is produced with vested interests, therefore cannot be neutral. Knowledge production is competitive, and usually those in "oppressed positions cannot have their point of view or create knowledge without questioning who they are" (Haraway, 1988: 586).

Collins (2000: 254) argues that there are certain social institutions that legitimize and validate knowledge, and these institutions are built on social relations of power. However, Foucault (1978) contended that power is everywhere and is not restricted to coercive institutions, as often being portrayed. This is because power emanates from social interactions of individuals. Where two or more people are interacting, there is often an attempt to exert power and control over others, and portray themselves and their version of the story as

ultimate realities. Thus, Foucault avoided the temptation to view power as wielded from top-down, but power as fluidity, can be widely dispersed and negotiated, and acknowledges diverse interests and multiple sites of power (Lupton, 2003; Bartky, 1990). The historical accounts and examinations of social relations of power in medical discourse have been traced to the work of a French philosopher Michel Foucault (1975), in book "*The birth of the clinic"* and "*The history of sexuality*" of the 1978. Foucault's historical writings has "reshaped the understanding, interpretations, and illustrates how network of power produces medical knowledge and medical experiences" (Lupton, 2003: 17). Foucault's theories of power and social control is best linked to various social institutions in modern Western societies, particularly medical institutions where he viewed certain illness as socially constructed and provided a different but radical ways of understanding the role of medicines in shaping certain knowledge and social relations of power that are inescapably part of medical experiences (Lupton, 2003; Foucault, 1978). Theorists like Foucault who have adopted social constructionist perspective view medicine and its practices as medical institution of power (Foucault, 1975), however the power does not only resides in institutions or dominant groups but also deployed by every individual through socialization of certain values and norms of behaviour (Lupton, 2003).

The current "conceptualization of medicine as *producing* knowledges which changes over time and space" (Lupton, 2003: 13), as elicited interests from scholars from various fields such as history, anthropology, sociology, gender, among others. This is because, medicine or medical institutions perpetuates social inequalities, results in potential conflicts and exert disciplinary powers on human bodies, thus resulting in docility or passivity. Many studies in healthcare systems follow this line of thinking. For example, Molina-Mula et al. (2018), in their wider analysis of the impact of inter-professional relationships from nurse's perspective on the decision-making capacity of patients in a clinical setting, found that "nurses continued modelling a type of patient passivity, or what Foucault called passive subjectivity in relation to oneself, because the patient is guided and directed to take charge of a truth provided by professionals." Molina-Mula et al.'s findings confirms Foucault's views on how docile bodies are constructed through exercising of disciplinary powers (Bartky, 1990). Chadwick (2018: 8 - 10) appropriated Foucault's theory of normative power relations to conceptualize birthing bodies in biomedicines and shows not only the docile and disciplined body but also the lived experiences and agency of birthing women. In another article, Chadwick (n.d., 2) "traces the epistemic violence through medical colonialization or appropriation of women's

labouring/birthing bodies." She further argues that "through various forms of epistemic violence, women/girls' pains, experiences and bodily knowledge are dismissed, suppressed and systematically erased" (ibid.). Niamsri and Boonmongkon (2017), in their study of bio-power, medical gaze and negotiation among Thai women, appropriated Foucault's theory of bio-power and discovered that "subjective experiences of ageing bodies as a sense of body-self and diversity of anti-ageing practices reproduce discourses practices to regulate women bodies as bio-power" (Niamsri and Boonmongkon, 2017: 62).

As can be seen from the foregoing, social constructionist perspectives such as Michel Foucault's theories of power and social control have been widely applied in the studies of relations of power in medical discourse. His historical work resonates today with Southern Africa as well as many global systems. His historical writings has shaped and continued providing an analytical and radical understanding, "and illustrates how network of power produces medical knowledge and medical experiences" (Lupton, 2003: 17). Thus, it can be emphasized that social relations of power are inescapably part of the medical experiences, knowledge production and experiences of illness. The following chapter discusses the research methodology - illustrating various methods used in medical sociology and feminists' studies.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology that was used in this study. It also introduces specific methods to address the research objectives, presents research design, methods for selection of participants, data collection and analysis. Drawing on various methods used in medical sociology and feminists' studies, Jefferys (1996) explains that the sociology of illness and health uses a wide range of methodological and theoretical frameworks because of its eclectic and co-existing with other social science disciplines. However, methodological choices are guided by the concepts, tenants and principles of the theoretical framework/s adopted by the researcher (Grant & Osanloo, 2014).

3.2 Research Design

Drawing on various methods used in studying health, illness, health systems, caring and curing and so on, in other words, research methods in medical sociology, this study employed qualitative strategy in data collection and analysis. Although, the studies in health and illness have predominantly used quantitative approaches (Faltermaier, 1997), there has been a mismatch between the diversities and complexities of human experiences vis-á-vis the certainties of biomedical solutions (Bradby, 2016), thus offering a platform for qualitative inquiry of health and illness. Historically, the field of medical sociology has been enriched by ethnographic and qualitative methods with an emphasis on the meanings, description, and medical concepts (Charmaz & Olesen, 1997). According to Faltermaier (1997), qualitative research methods offer new insights, meanings; enables the researcher to reconstruct the meanings, and perceive a layperson, as experts over his/her own life. Nonetheless, Rahman (2017) argues that qualitative approach, holistically explores human experiences in particular settings, thus offers detailed account of participants' feelings, experiences, and opinions and elucidates the meanings of their action.

3.3 Study Setting

The study was conducted in Chadiza district of Eastern Zambia. Chadiza district is a small city situated on a plateau between the Luangwa valley and the great Zambezi river basin. Its population is just over 70, 000 people (CSO, 2014). Agricultural production for subsistence is the major source of survival in this region (Bwalya, 2018). This region and its people have

felt the sting of austerity policies since the early 1990. Since its creation as a district in 1946, Chadiza has lacked health infrastructure; its first health facility opened in 1970s.

3.4 Study participants

The study participants comprised of women and men aged above 18 years who were residents of the study area; and who had visited any of healthcare systems or healthcare provider in the previous two years. Although the study focused on women because they are the most marginalized in both private and public life, but primary seekers of health for their families, this study also wanted to find out reasons why men put more responsibilities on women for health of their families.

3.5 Sampling strategy

In social science, researchers make selection or sample participants from the population and make generalization from (Seale, 2011). Therefore, the aim of sampling is to provide good estimates by using limited cases, about the nature of the whole population (Seale, 2011: 135). Sampling is a strategy used to select the units of analysis upon which data can be drawn, compared and analysed (Bhattacherjee, 2012; Babbie & Mouton, 2001). Bryman (2012) also explains that the unit of analysis is simply the study sample. In this study, purposive sampling was used as a way of selecting participants. In purposive sampling, the selection of study participants are based on known characteristics (May, 2001). In this study, the unit of analysis was the household and the selection criteria were: women and men aged above 18 years who were residents of the study area; and who had visited any healthcare system or healthcare provider in the previous two years. The two years period was based on an assumption that a person might have fallen sick or a member of household and sought care from any healthcare systems or providers.

For secondary data, the criteria for selecting the documents was done in stages. Firstly, the scope of searching was established using key words such as *health statistics; health services; Western medicines; biomedicines; traditional medicines; healer;* healthcare systems in pre-colonial, colonial and post-independence Zambia. Electronic databases and manual search of library catalogue was conducted using key words. Secondly, analysis of the titles and abstracts of articles and any other documents to include only those that address biomedical medicines; Western medicines; traditional medicines; heath statistics; health services; and health systems in Zambia.

3.6 Data sources and evidence

This study drew on both the ***primary*** and ***secondary*** data sources. The use of secondary data sources helped to obtain existing information on the history, pattern of use and described the current health systems in Zambia. As Mechanics (1989) notes that secondary data sources often provides wealth information, efficient and typically familiarizes the researcher with large and high quality samples. In this case, secondary data informed or laid the groundwork for primary research purpose. Usually secondary data is more relevant and used whenever the topic of interest is not yet fully established and it becomes suitable for answering the researcher's questions (Bhattacherjee, 2012). On the contrary, analysing secondary data requires critical interpretative skills to discover the meaning of the material (Bryman, 2012).

The ***secondary*** data was collected from published material such as; government statistics; reports; published commissions; health annual reports, demographic health surveys and related materials; published work of anthropology and public health experts and historians; newspapers and health reports as well.

The ***primary*** data is the original, first-hand data that the researcher collects to understand the experiences and learn more of the real world problems and observable phenomena (Driscoll, 2011). In this study, primary data was collected from study participants through semi-structure interview guide. As Bryman (2012) states, semi-structure interviews are flexible and give room for raising complementary questions. By asking additional questions, the researcher begins to identifying key themes and recognising the similarities and differences from the data collected.

3.7 Data collection method

In this study, method triangulation for data collection was employed in order to comprehensively understand the phenomenon and to ensure high qualitative data (Carter, 2014). Method triangulation involves collection of data from multiple sources to gain different perspectives and validation of data (Carter, 2014). For instance, "method triangulation" is used in feminist approach to give opportunities to the voices of marginalized groups and brought them into direct conversations with the data in order to gain understanding (Mertens & Hesse-Bibers, 2012).

For ***primary data collection***, semi-structured interviews were used to collect data from participants. Semi-structured interviews were conducted with seven women and seven men

who were residents of the study area and were above 18 years old. The study participants were approached and asked to participate in the study after preliminary interview to ascertain their suitability for the study. Thus, basic questions were asked about their marital status; whether they had themselves or on behalf of the family sought care from any of the health providers or facility in the last two years.

According to Bryman (2012), semi-structured interviews allow the researcher to be open-minded about the contours so that during the exchange of information with the participants, theories and concepts can emerge out of the data. Semi-structured interviews have been widely used and attracted interests in qualitative studies. The increase in use of semi-structured interviews is based on the assumption that research participant's viewpoints are more likely to be expressed openly than in a standardized questionnaire or interview (Flick, 2009).

The interview guide was translated into a local vernacular language (Chewa) because of low literacy level (46.9%) (CSO, 2014) and the interviews were conducted in that language. Given the fact that the male researcher conducted the interviews, it was anticipated that interviewing women on issues of family health and caring might result in objection. However, just like during my previous Honours research experience, no objection recorded from all women who participated in the study given the wide use and acceptance of all different healthcare systems, be it traditional, biomedical and religious healing (Bwalya, 2018). Nonetheless, for women participants who might have felt uncomfortable to be interviewed by a male researcher in unlikely circumstances, ethical clearance was sought to hire an experienced female research assistant. A non-disclosure agreement (see attached as **Appendix C**) was developed and the assistance would have signed it before conducting interviews. This would have been done to ensure confidentiality of data collected and protection of study participant's identity. However, as it was anticipated, there was no objection from any participants approached. The interviews were conducted at a time and venue appropriate to the participants.

My field experiences during data collection

After obtaining ethical clearance, I spoke to and arranged for interviews with a few potential participants. However, I only started interviewing people after receiving my final ethical clearance letter.

I was deeply conscious as I entered into the field work that sometimes I could experience difficulties in approaching and interviewing female participants – especially those who were married and entirely depend on their husbands for survival. As a male researcher, I approached this challenge by having to obtain double consent (permission), one from the husband (verbal consent) and from the female participant (written). As a result, I could not interview one woman because I had no chance to meet her husband. However, I had to find another woman to replace the one I had approached earlier. Nonetheless, it was not difficult to approach and interview male participants. Male participants on the other hand did not need get permission from their spouses or inform their wives before interviews. This shows how patriarchal norms has deeply entrenched in Zambia societies. Even those working-class women, it was not difficult to approach and make an appointment for the interviews.

The interviews were conducted in three different languages. All participants had their own choice of the language to use. Fortunately, I was able to speak all the languages people use in that community. Although, the most predominate language is Chewa.

I also visited the first Christian Missionary Centre to be established in Chadiza and their Reformed Church University in Lusaka. The mission centre is located 25 kilometres away from the Chadiza district centre. During my tour, I was oriented and had a fruitful discussion with the Pastor in-charge of the mission centre. He also directed me to their University in the capital city of Zambia where I found valuable books and other documents written about the church's activities since its inception in Eastern region of Zambia, including their medical services, particularly my study area.

Secondary data collection was collected through the hermeneutic phenomenological approach, in order to understand human experiences in an imbricated health system. Hermeneutic phenomenological method attempts to "unveil the world as experienced by the subjects through their life world stories" (Kafle, 2011: 186). Its main concern about lived experiences or human experiences as lived (Laverty, 2003), has attracted interest and has been widely used in social research. Its proponent, Martin Heidegger, emphasised the historical understanding of one's background or one's situatedness in the world (Laverty, 2003). In this study, the use of hermeneutic phenomenological approach was to understand and describe historically multi-layered health systems; sociology of health and healing; and patterns of use during pre-colonial, colonial and post-independence Zambia.

3.8 Data analysis

Discourse data analysis was used to analyse primary data. Discourse analysis focuses on how language is used in a social context (Miles, 2010; Kawulich & Holland, 2012; Thorne, 2000). Underpinned by the social constructionism that postulates that there are multiple and competing realities, it is imperative to understand the text or discourse being analysed (Kawulich & Holland, 2012). Social constructionists assume that language shapes reality and how people understand human behaviour (Miles, 2010; Kawulich & Holland, 2012). In this case, language refers to the text or talk/speech and context refers to the social situation in which the text or talk occurs (Miles, 2010).

Although, there was no sequence or step-by-step process followed by the researcher when analysing discourse, the researcher identifies phrases, recurring terms, metaphors and analogies used and verbiage indicating opposing ideas (Kawulich & Holland, 2012). It was also important to find differences and similarities of textual discourses. In this case, the goal was to understand and interpret the relationship between language and social context.

For secondary data analysis, hermeneutic analysis method was employed in order to identify predominant themes from the texts. According to Patterson and Williams (2002: 27), in hermeneutic data analysis, "the first text is collected so that emergent themes are identified and used to guide further research." In hermeneutic analysis, the "text" stands for an individual actor, and "data" is seen as situated construction (Patterson & Williams, 2002), through which the interpretation of meaning is produced (Laverty, 2003). In doing hermeneutic data analysis, predominant but specific themes were identified; and narrative accounts were produced, presented and interpreted.

3.9 Ethical Considerations

It is important that the research process be guided by ethical principles and requirements. According to Wassenaar (2008: 61), "research ethics should be a fundamental concern for all social science researchers in their studies involving human participants, thus ethics should guide all research processes including planning, designing, implementing and reporting." In qualitative studies, emphasis is made on adherence to basic ethical principles; informed consent, right to privacy, confidentiality and protection from any harm (Rahman, 2017; Wassenaar, 2008).

Therefore, this study adhered to all the ethical requirements of the Research Ethics Committee of the Faculty of Humanities at that University of Pretoria. In the execution of my study, I followed the four basic research ethical principles, namely: informed consent, confidentiality, right to privacy, and protection from any harm. Prior permission was sought from every respondent and I assured them of utmost confidentiality for any information given during the interviews. There was no disclosure of information to any third party without participants' written permission; and that any data reported in my research report did not include any information that identified participants. Through the informed consent form (***see Appendix B***), I was able to notify the participants about their rights to withdraw at any time if they want to, and no participant was compelled to participate, thus their participation was completely voluntary. With permission from the participants, all the interviews were audio-recorded and if I had any participant who did not want to be audio-recorded, I would have taken note of that and I would have taken notes instead. But all participants accepted to be audio-recorded. The informed consent form was translated into a local language (Chewa) for participants to understand and interviews were carried out in the same language. The purpose of the study was explained to the participants before participating in the study and that was; the study was for academic purposes only. In addition, I make available the details of the Psychosocial counsellor at Chadiza Hospital Social Services Department to all the participants for counselling and/or debriefing in case of any eventuality or if needs arose. (see letter attached ***Appendix E***). These psychosocial counselling services are provided free of charge.

In summary, this chapter illustrates common research methods used in medical sociology and feminists studies and points out challenges I encountered during fieldwork. The chapter concludes by discussing the ethical considerations. The following chapter discusses research findings with a focus on the analysis of the power dynamics that exists in different places and spaces of healthcare systems.

CHAPTER 4. SOCIAL RELATIONS OF POWER

4.1 Introduction

This chapter culminates in the analysis of the power dynamics that exists in different places and spaces of healthcare systems. The chapter forms the basis of the analysis of complexities of decision-making, and examines the unequal distribution of power relations, hierarchies, and the existence of the power struggle in household, traditional, religious and biomedical healthcare systems. The chapter also gives an account of power relations of individual's encounter of illness and experiences of different healthcare systems.

As discussed earlier, it is asserted that in terms of social construction theory, what is seen to be truth, is actually the product of social relations of power (Berger & Luckmann, 1966). Because the truth or knowledge is produced with vested interests, thus cannot be neutral (Haraway, 1988; Collins, 2000; Narayan, 2004). It is also important to note that the oppressed cannot have their knowledge or point of view without questioning who they are (Haraway, 1988: 586). Appropriating Foucault's ideas, who has adopted social constructionist perspective and view medicine and its practices as medical institution of power (Foucault, 1975), it can be argued that social relations of power are inescapably part of the medical experiences, knowledge production and experiences of illness. This is because as Foucault, 1978) argued power is ever-present in all human social relations. In this case, where human interaction exists, there is always an attempt to exert power and control over the other (ibid.). Therefore, in this study, I start by examining the social relations of power at household level where decision-making about health choices results into human interaction and influences of health outcomes.

4.2 Household level

In this study, the household is placed at the centre of analysis of social relations of power. The focus of this section is to illustrate the interplay of traditional ideas of what it means to be a husband (man) in relation to being a wife (woman) in household. In a household, decision-making about healthcare choices is largely influenced by the power dynamics that exist between spouses. The complexities of household relationships in which women's autonomy and power is often vanquished and men usually emerge as winners in any dispute or decision making process is at the root of the enduring patriarchal relations, gendered division of

labour, social and economic marginalisation of women. The household is also not isolated from societal structures that define and dictate the roles of spouses. In my fieldwork, I found that despite some gains legally and socially, powerful societal expectations and socially norms that dictate the status and roles of men and women at household level continue to relegate women to lower positions and elevates men in households' decision-making. This gives rise to the continuation of a gendered division of labour at household that is enacted through socially constructed roles in which women are seen as merely caregivers and men as breadwinners (Connell, 2005). Mkhwanazi, et al. (2018) states that since care is deeply gendered, women are expected to, for instance provide childcare and do other forms of routine caring for the family such as cleaning and cooking. Thus, it is evident that women continue to take-up a huge burden of caring for the family. However, women's autonomy and agency in healthcare choices are limited. Even in the emergence of HIV/AIDS diagnosis and treatment, which swept through most countries in Southern Africa including Zambia in the 1990s and 2000s, has not undermined this and drawn women more obviously into equality in care seeking with men. This is because cultural practices put women at high risk, undermines women's autonomy, and jeopardizes their health (Ngoma, 2016). Yamin et al. (2005), in their wider analysis of the gendered power relations about maternal and child health in sub-Saharan Africa found how women's agency about childcare decisions is limited, thus resulting in a significant gap in meeting children's healthcare needs. Mkhwanazi (2018: 72) states that "decisions about childcare are not straight forward." It is a process that involves negotiations within the household, however in most African communities, men generally felt that they are culturally entitled to make decisions regarding the health of family members. As a 34 year old male respondent explained:

> *"I make decisions because I am the head of the house. A woman is supposed to listen and obey my instructions or decisions. If I tell her to go to the hospital, she has to go. If I tell her to go to the traditional healer or for prayers, she has to follow my instructions because I know what needs to be done in order for her to be cured."*

Another male participant aged 27 added:

> *"It's me… as a man, I am supposed to decide. I am the one who is supposed to decide at what point I should take any member of my family to either the hospital or traditional healer."*

There are certain cultural practices and beliefs embedded in Zambian society that affect women's wellbeing (Ngoma, 2016). Such traditional beliefs and practices that make men as head of household and breadwinners enact and enhance men's domination. In addition, the culturally construction of men as head of household exert influential powers and enables men to occupy higher power position at household level. Such traditional beliefs and practices characterise men as "heads of households" and "breadwinners" even if they are not the sole earners and even if they are unemployed and these are deeply enacted by men and women, and enhance men's domination. These constructions lies at the heart of cultural scripts that allow men to exert influence and power. There are variations emerging, however, in groups of more highly educated men. The above explanation by 34 and 27 years male respondents elucidates the dominant position of men. When male participants were asked to state the reasons why their partners (wives) cannot make decisions on family member's health or their own health. The majority of participants insisted that they were the head of the household, hence they find it reasonable to make decisions. As one very typical male participant, aged 58 years stated:

> *"My wife waits for me because she knows I am the head of the house. I am the one who can make a proper and final decision. After all, she has to show respect to me as a man."*

Another male participant aged 31 years reported that:

> *"I make decision because I am the head of the house and I know different types of diseases and their symptoms. My wife can only make decision if I am not around and if the health condition of a member of family is worse. So there's no need to wait for me."*

In this study, it was found that men felt that, by following their instructions and submitting to their demands, women were actually showing respect to their partners (husbands). However, the study found variations among male participants. Those male participants who attained tertiary education and employed seemed to be flexible when it comes to decision-making at household level. As one male participant aged 26 years, attained tertiary education and currently in permanent job explained:

> *"If I am not around my wife may make decisions and later on, report back to me. If I am around, we sit down together and decide what to do. But if my*

wife and I are around, we consult each other as to where we can go first for healthcare services."

The study generally shows that men have powers over women in terms of decision-making at household level. In interviews, women informants also described and situate men in a dominant position and seemed to accept and submit to men's demands. The study also found that women were actually reinforcing the dominant positions men held in household by acknowledging and accepting that men were heads of household and decisions should be made by the head of household. Ganle, et al. (2015) states that the traditional interpretations and definitions of women as particularly accommodating, obedient, subordinate and submissive to men creates an environment in which women become powerless and often depend on men, including decision-making regarding healthcare choices and outcomes. This also naturalises male control for both women and men, as a female participant, aged 37 years, explained:

"My husband makes decision because he is the head of the family."

Because men are dominant and seem to possess powers particularly in relations to women, men's masculinity perpetuates imaginary power inequalities. This can be seen in men's common practices of escorting their women to health facilities at night when they or any other family members were sick. When asked why their partners were not escorting them to health facilities during the daytime, women pointed to security reasons at night and they felt that men provide security or fight back whenever enemies or wild animals attack them. Such statements by women already puts them in a weaker position and direct acknowledgement that they (women) are weaker than men are. As a female participant aged, 28 years stated:

"When I am sick, or my child is sick, I go alone to health facilities, unless at night that is when my husband escorts me because I need protection."

Despite men, claiming that they had powers to make decisions regarding the health of their family members, women's participation in decision-making about health choices appeared to be more flexible in household where women were educated and economically empowered. This finding is similarly to a study conducted in Ghana by Ganle et al. (2015), where women who were educated and dwells in urban areas enjoy a greater freedom in participation in decision making regarding access to skilled care than rural and uneducated women. As one female participant aged 39 years whose highest level of education was tertiary, although unemployed stated:

"My husband and I make decision if any member of the family is sick. But if I am sick, my husband decides and if he is sick I also advise him to go to clinic."

Another female participant aged 31 years who was educated and in permanent employment added that:

"If I am the one not feeling well, I decide because my husband would want me to go and seek care from a herbalist or hospital but I am the one feeling that pain and I know where I can get help. So I need to decide. But if one of our members of the family is sick, my husband and I sit down together and make a decision."

Apart from men (husbands) making decisions over women (wives), the study found that older women (for example, grandmothers, mother-in-law, their own mothers) were also making decisions over young women with regards to maternal health. Similarly, to the findings of the study by Ganle et al. (2015), which shows that senior family members such as grandmother, mother-in-law, or community heads often make decision on behalf of maternal mothers. The study by Ganle et al. provides an insightful on how social factors influence and renders less autonomy and stiffen dependence of women on others to make decisions. Similarly, in a study conducted in Kalomo district in Zambia by Sialubanje, et al. (2015) found that women lacked autonomy in decision-making regarding childbirth and they dependent on their husband and other family members to make decision. In this study, age difference also plays a key role in decision-making as some female participants explained that their older family members decided as to where to go and seek care or at what stage of their condition (especially during pregnancy) they could seek healthcare and from which healthcare system or health providers. Sometimes older women's power approached that of junior men, as this example shows. A female participant aged, 31 years explained:

"I was due for pregnancy review in that month but before the actual review day, I started feeling pain. I thought it was indication for pregnancy labour and my legs were swollen. So my mother decided to take me to the hospital."

Another female participant aged 37 years explained:

"My mother-in-law told me not to go to hospital because of the type of disease, instead she advised me to go to the traditional healer."

Health seeking and decision regarding intervention during illness involves an individual, a network of friends and families (Booyens, 1991; Batisai, 2016). It is within this social network that diseases are first experienced, diagnosed and treated (ibid.). In this way, a wide range of therapeutic measures is taken to restore the wellbeing of the person even before seeking care from established health systems and providers. This reality sometimes undermines or complicates the binary division of gender, without eradicating it as a key fault line. In this way, illness makes people to be subjected to multiple and intricate patriarchal power relations that limit the ability to exercise their agency, renders less autonomy and inhibits access and use of healthcare services. I found that despite having less decision making powers, women still do a bulk of caring work within the home. This requires great strength and courage, and yet is not seen as a strength compared to men's physical strength at repelling an attack by criminals or animals. Some women can be seen as weaker – by themselves and by men – even though objectively they carry many heavy responsibilities and challenging roles.

4.3 Institutional Level

The influence of social institutions on people's lives, shape their experiences and inescapably affect ways in which they organize their interactions (Bottorff, et al., 2011), thus social institutions become arenas in which social relations of power are enacted and reproduced. In my interviews with key informants, I found that a person moving into different spaces is subjected to different forms of power relations. Hence, the strings of power relations and people's agency from household level do not disappear as people enter the institutional spaces. But that some of this power hierarchies work in different ways depending on spaces.

4.3.1 Biomedical healthcare system

The power relations encountered in biomedical healthcare systems shape the provider – patients' relationship and determines ways in which the provider relates to the patient and vice versa (Paynton, 2008; Molina-Mula, et al., 2018). In this way, hierarchies of division in the household can be seen to have mirrored in the clinical space. Thus, the power relations

between the healthcare provider and patients reaffirm existence of power differences in which the provider operates with a degree of institutional powers, which is not available to patients (ibid.). Thus, power imbalance that pervades healthcare systems enables the provider to give directions on the treatment path. Paynton (2008) observes that, although formal power distribution characterized healthcare systems, health providers communicatively exercise informal power strategies in their execution of duties. In this way, health providers influence the outcomes of patient care by using informal powers available to them (ibid.). In this study, men and women interviewed felt that biomedical healthcare providers had more powers than patients do:

> *"Those people (nurses) are given powers by the government, so you cannot go and complain anywhere and expect any action to be taken."*

The study also revealed that regardless of perceived gender (male or female), patients were not consulted or given treatment options, resulting in frustrations and displeasure. In this case, men felt more frustrated as they thought they were feminized or reduced to being like women in clinical settings. The hegemonic masculinity that requires men to act and be in control contradicts the biomedical demand of a 'good patient' who is expected to be passive and take-up instructions from health personnel and engage in health-enabling behaviour (Skovda, et al. 2011). However, in healthcare spaces, this hegemonic masculinity is threaten and men are feminized resulting into frustrations.

Several studies have called on a balanced provider-patient relationship that may result in care provider working together with patients as partners in decision-making (Paynton, 2008; Eliassen, 2015; Molina-Mula, et al., 2018). On the contrary, this study reveals the power imbalances and hierarchies that result in emotional abuse of patients as study participants revealed that:

> *"Some health workers are heartless and they abuse patients by insulting and shouting at them. Some nurses do not even care whether you are older than they are or not. I was attended to in a rude way. They even mistreated my relatives who came to visit at the hospital and even the one taking care of me, was in trouble."*

It was also reported that patients were not part of decision-making or consulted about their preferred mode of treatment. As a male participant, aged 27 years explained:

> *"I was upset when a black doctor told me that he was going to remove my kidney. I was not even consulted or given proper reasons why he wanted to remove my kidney. Fortunately, a white doctor declined and advised other doctors to do more investigations. When the results came out and reviewed, the white doctor indicated that the problem was not complicated. It had just started and they could not proceed removing my kidney. I would have lost my kidney just like that."*

The study further established that patient's accounts about their experiences of the conditions/disease were ignored in biomedical healthcare system. This finding is similar to the finding of Molina-Mula, et al. (2018), which revealed that health workers often abandon the idea of teamwork and constantly exclude the patients and family members from decision-making. Health workers see patients as passive subjects, thus directing and guiding patients on treatment path (ibid.), and any mishap or doubt by patient results in sour relationship between the provider and the patient. This study reveals that health workers were humiliating and shouting at patients – both men and women who asked questions or passively respond to instructions or medical procedure/s undertaken, although it was reported that female health workers frequently abused patients:

> *"I didn't ask questions because if a patient start asking questions, some nurses respond well and give you an explanation but majority of them think that you are disturbing them. Hence, they shout at patients. Last time when I tried to ask a question, that nurse shouted at me and told me that I was not supposed to ask questions about what she was doing…. "I know my job"….she said."*

When patients are provided with information necessary to make informed medical decision, and when a person (in this case, a nurse or any health worker) who is perceived to be in authority invites questions from patients or ask patients to give opinion, it is more likely that patients will actively participate in treatment process. Despite the evidence for this approach, health personnel rarely involve patients in decision-making or consult patient and seldom give them available treatment options so that they can make informed decision about their health or healing process. Worse still, and even in difficult circumstances whereby patients (especially pregnant women) who were about to lose their babies, health personnel rarely

consulted or gave patients enough information or treatment options for them to make informed decision. As a 31 years old female participant reported:

> *"I had an induced delivery. I had a prolonged labour and they (doctors and midwives) decided to induce the process to accelerate delivery of the baby. That's how I delivered a baby."*

Another female participant, aged 27 years explained:

> *"When I arrived at the hospital, my BP (blood pressure) was high. So the doctor and nurses decided to terminate my pregnancy due to sudden onset of preeclampsia. They (health personnel) induced labour and I delivered a stillbirth (dead baby). The baby died because it was premature birth. In fact, it was a fresh stillbirth. That is how I survived."*

When asked what she meant by the statement "*that is how I survived*." The participant explained that health personnel decided to terminate the pregnancy as a way of saving her life because if she had kept it, she might have died because of sudden changes of pregnancy condition. Generally, the study shows how medical personnel capitalize on "fear of death" by health seeking people to manipulate and appropriate their ideas about health outcomes. Chinyere and Bonaparte (2016: 4) established that "there is a constant evocation of the culture of fear in labour and delivery wards by medical staff to elicit compliance in unruly birthing women."

All these strategies make patients to surrender their bodies and adhere to medical demands. Thus, patient's accounts of experiences of subjugation when illness confront them, show how they are subjected to different forms of power relations as they seek care and that they think about and do not forget these painful and scarring interactions. The ramifications of these experiences shapes their health behaviour afterwards and it seeps into every aspect of their lives.

Furthermore, the expectation of health workers for patients to remain subordinate, subservient, and control their movements and space is challenged by patient's desire to resist. Thus, healthcare spaces become arenas of conflict and power struggle. Often, patients resist, and do not want to comply with unnecessary orders or imposed treatment or care (Molina-Mula, et al., 2018). Across the world, research by sociologists and other social scientists as well as medical researchers have shown that in most biomedical contexts,

patients assume a passive role, and do not assert their will; do not question or protest; and often obey all commands from health personnel. However, there are complex dynamics not always visible at work, whereby patients exercise their agency but in ways that are not always visible in the clinical encounter. This study show how patients have some less visible ways of keeping some agency in the encounter of medical violence. Similarly, to the study conducted at Kalene Hill in North-western of Zambia by Kalusa (2014), which revealed the unobservable ways in which patients exercised their agency during their encounter with missionaries' medicines. According to Kalusa, "the patient's powers manifested itself in myriad but often unobservable forms of behaviour" (ibid.: 292). Another study conducted by Mwamba, et al. (2018) shows how HIV-positive Zambians disengage from care despite having access to free antiretroviral therapy. Although there are several contributing factors for patient's disengagement from HIV services, Mwamba et al. study shows how patients were aware that health personnel were mistreating them, hence decided to disengage from the HIV treatment programme (ibid.).

This research has shown the indisputable fact that in this form of a biomedical healthcare system, patients are seen as passive and subject. Thus a "good patient" often assumes a strictly passive role, not protesting or questioning and obeys all commands from health personnel (Molina-Mula, et al., 2018: 2). Similarly, Kalusa (2014: 292) found how "historical records and missionary iconography depicted mission doctors as heroes who acted upon the prostrating, passive African sick." However, Kalusa was also quick to point out ways in which African patients demonstrated their resistance to missionary medicines (ibid.). Similarly, this study established that patients opt to remain silent even in situations whereby they knew they were abused. They did that for fear of further abuse, humiliation, neglected and a way of protesting:

> *"When a nurse shouted and humiliated me, I just kept quiet because I needed help from her (nurse). I was also afraid that if I responded, I might complicate the situation and they (nurse) might give me medicine that could not cure me or cause more damage to my health."*

Another participant added:

> *"I was very upset, although I didn't respond. I kept quite as a way of protesting. I did not trust the nurse. The way she shouted at me, I was even*

afraid that she might give me other medication that will kill me. That was a reason I kept quiet."

When participants were asked, who abused them or who were the most abusive worker in health facilities. They reported female nurses as perpetrators or the most abusive health workers. Although, studies about patient's abuse at the hands of nurses do not specify the gender category of nurses, it can be affirmed that female nurses are the most likely culprits, given the clinical spaces such as antenatal care, maternity and labour spaces in which several studies reported abuse and clinical negligence (Jewkes, et al., 1998; Mathole, et al., 2004; Hastings-Tolsma, et al., 2018); and these clinical spaces are dominated by female nurses as a result of "gendered division of nursing, and its explicit connection to womanliness" (Burns, 1998: 695). However, a complex interplay of factors and a combination of women onuses feeling overwhelmed but then also using the little professional powers they have over both women and men patients illuminates the reasons for abuse.

However, during interviews, my informants reported nurses who were working in rural health posts were actually more respectful than the nurses who were at central hospital. This shows that the least hierarchy between the rural health nurse and the community whom she/he lives with, treat their patients with respect, similarly to the way traditional healers treat their clients with respect.

4.3.2 Traditional healthcare system

Historians, anthropologists and sociologists have studied traditional healing and religious system for quite long (Kalusa, 2014; Flint, 2008; Vaughan, 1991; Chavunduka, 1994; Ngubane, 1977;; Turner, 1968). For example, as early as 1940s, Turner (1968) started investigating the traditional religious system of the Ndembu people of North-western Zambia. His focus was on the studies of "rituals in broader terms of its symbolic structure, its purported aims, and its implications for social relations, social structure and the dynamics of social cohesion and conflict. He also provided an extended description of the basic aspects of divination by which the Ndembu people determine the various causes of misfortune and hence the kind of ritual to be used in removing or curing" (Beidelman, 1969:92). Turner's study brings together the ideas of medical knowledge, culture and traditional religious, and provides a fascinated explanation of the implication of social relations of power, cohesion, and conflicts in medical practices. However, in all these traditional healing and religious system of the Ndembu people, Turner (1968: 22) observed

that the use of esoteric language of symbols about the nature and meaning was paramount. The emphasis on the use of local language and shared cultural background between the patient and traditional health practitioner as well as having common world-view and experiences is good enough to attract people to traditional healing (Gibson, 2013). There are many other different reasons people seek care from traditional healers, however studies have shown that cultural resemblances, common language and similar understanding of diseases between traditional healer and patients makes traditional healing a primary choice. Manglos and Trinitapoli (2011) also states that health seeking behaviour is motivated by deep-seated cultural forms and individual experiences.

A few studies also show good treatment outcomes (Gibson, 2013). In addition, sociocultural factors make people especially expectant mothers to seek care from traditional midwives, as they are traditionally and culturally appropriate (Cheelo, et al., 2016), thus making them observe traditional rituals and culturally take care of patients better than in public health system. Similarly, in this study, participants who visited traditional healers had no trouble interacting and asking questions about their health. This is because patients were using similar language; had similar interpretation and understanding of diseases, and had great cultural similarities with traditional healers. Participants also reported that traditional healers treated their patients with respect, calm and everyone was attended to accordingly, regardless of the age, gender or socioeconomic status:

> *"I was given respect and treated well. Traditional healers treat clients with respect. I think it is one way of attracting people."*

Traditional healers also made sure that their patients understand instructions given before the use of their medicines. These includes instructions on preparations, timing and dose of herbal medicines. Similarly to what White (2015: 4) reported that traditional healers prescribe herbs to patients and prescription comes with specific instructions on preparation, dose and time-frame:

> *"Traditional healers respect their patients and they make sure that a patient clearly understand instructions before using their medicines. They (traditional healers) don't shout at patients, unlike health workers, who forget that they were employed because of patients."*

The study reveals that during traditional healing, people are allowed to ask questions and sometimes demand for an explanation before taking part in the ritual performance or use of

traditional medicines. Thus, study participants believed that by allowing them to ask questions about herbal medicines and other ritual practices they went through, they became part of decision-making about their healing process. However, in traditional healing system patients are expected to be passive. Turner (1969: 22), in his ethnographic study about the Ndembu people observed that "patients who underwent traditional healing were passive to the actions of the ritual and received the stamp of its meaning." Patient's possessions, status, social connections were stripped off during traditional ritual performances (ibid.). This passivity has repercussions for social relations, cohesion and conflict that may arise.

Although there were no forms of abuse reported by participants in this study, several studies have shown rampant physical and emotional abuse associated with traditional healing (Gibson, 2013). In South Africa, it was reported that people have been killed, assaulted, raped and even robbed especially during traditional ceremonies (ibid.). Thus, traditional healing spaces are not free of violence or abuse; in fact, they are spaces where violence and sometimes even death can occur.

4.3.3 Religious healing system

Both clinical and traditional medicines are medicated and interlinked to people's strong religious sense of being in the world. During interviews with my informants, I found that the existing regional healthcare system is highly embedded with strong Christian elements and people draw on Christian values and understanding of illness as they seek care. Nonetheless, Booyens (1991: 481) stated that "ill-health may to some people be a deep and meaningful spiritual experience." This is because religion as a body of healing system emphasises on the spiritual and physical wellbeing of an individual as well as the community at large. Thus, religious healing practices becomes a communal affair and contributes to community health (Manglos & Trinitapoli, 2011). In this way, the healing process, just like illness is transformed from being a private matter to public concern. In Southern African independent churches, public healing during church services and private consultation with religious healer are common (ibid.). Holding of public religious healing services minimizes the changes of healers abusing patients. In this study however, majority participants pointed to various reasons which make them seek care from religious healing system, and these are, among other reasons; easy access and availability, free services (although members take gifts), no discrimination, quick to attend to patients, calmness and respectful way of treating patients:

"I was properly taken care of. Religious healers know how to treat people, unlike health workers who mistreat their patients."

While study participants did not report any form of abuse or discrimination based on gender, class or economic status, the religious advocacy for equality and freedom can be traced back to the early Christian missionaries (Mwaura, 2007). Mwaura further points to the importance of biblical teachings, which demand for equality, mutual respect and obedience virtually within human social relationships (ibid.). Although there seemed to be mutual respect and obedience between the religious leader and followers, the fact that the church structures and prophetic gifts puts religious leaders in authority, makes it possible for them to exercise powers, command respect and influence the church (ibid.). Thus, leaving room for abuse of church followers. Calitz (2014) cites several examples of sexual assault perpetrated by religious leaders from the Roman Catholic, Dutch Reformed Churches and other religious groupings in South Africa, and claimed that the perpetrators are often people in authority whom the victims might have trusted. It is undeniable that religious spaces are not free from manipulation, violence and abuse. In fact, they are also spaces where unequal distribution of power occurs.

In summary, the chapter demonstrates the existence of plural healthcare systems that allow people to draw on various forms of healthcare, ranging from family-based, traditional and biomedical regimes and medicines. However, these healthcare systems become arenas of conflicts and power struggle, as men and women move into different places and spaces in search of healing; they are subjected to unequal distribution of power relations, starting from household level where initial decision-making about health choices are made, to traditional, religious and clinical spaces. This section demonstrates that people's search for health is not teleological but a veritable matrix of health seeking patterns. This section also shows that, as people are subjected to various forms of formal and informal power relations, their agency do not disappear.

CHAPTER 5. SOCIAL STIGMA AND DISCRIMINATION

5.1 Introduction

In this chapter, I intend to demonstrate how my findings emerged from participants' experiences across various healthcare platforms set out in the previous chapter. This chapter focuses on the social relations of power, stigma and discrimination and how these factors interplay and are interlinked to gender, class, age and other forms domination and people's agency in seeking health.

5.2 Stigma and discrimination

5.2.1 *Based on age*

Several studies have focused on gender, class and racial discrimination, however little is known about discrimination based on age of the patient. So far, numerous studies on stigma and discrimination focus on health status especially on mental health and HIV/AIDS status (Yuan, 2007; Reis, 2005; Mathole, et al., 2004). In Western countries, class, race, sexual orientation and migration status are at the intersection of discrimination for health service provision (Gazard, et al., 2018). However, a study conducted in Zimbabwe by Mathole, et al. (2004) found that older women attending antenatal services were categorized as a high-risk group. Yuan (2007: 292) stated also that age discrimination is predominant in medical and workplace settings. Thus, old people are stereotyped and usually perceived as powerless, incompetent and in need of help. In this study, although the age of a patient was not the main reason patients were stigmatized, humiliated or discriminated in healthcare systems, older patients complained about lack of respect and calmness as medical personnel attended to them. For majority of participants who sought care from public health facilities, everyone was attended to or received the services as a patient regardless of age, except on instances where a patient was of a certain age group. For those elderly patients, their age group sometimes gave them advantages over other patients - of being attended to first, and quickly received the services. However, a 58 years old male participant explained that regardless of a patient's age, biomedical health providers subjected patients to verbal abuse:

> *"I have been seeking care from these health facilities for a long time now and if you find a nurse, who is treating patients well, then you are just luck that day. Sometimes I find some nurses who treat me well because of my age*

and they will quickly provide services to me but some nurses don't even care whether you are older than them or not, they just treat you rudely."

As the next section will show, this was exacerbated in situations of gender hierarchy.

5.2.2 *Based on perceived gender difference*

It is well documented that discrimination of people based on gender is inextricably connected with other factors such as race, ethnicity, religion, age, social class, sexual orientation and health status (Collins & Bilge, 2016; Yuan, 2007; Gazard, 2018). These social, economic and health statuses give people access to, and sometimes prevent them from accessing health services. In a study conducted in USA about social discrimination in healthcare systems, D'Anna et al. (2018) found that social discrimination was highly linked to avoidance of healthcare services and non-adherence to treatment. D'Anna, et al. findings can be linked to the findings from a study conducted in Zambia by Mwamba et al. (2018), which shows that stigma, lack of confidentiality and social support for people living with HIV leads to sourcing alternative HIV medication. However, this study found that participants failed to identify acts of perceived gender discrimination or stigmatization in all healthcare systems:

"Gender difference is not a factor in the way patients are taken care of or treated by healthcare providers. Everyone is attended to as a patient."

However, study participants noticed that there was gender policing and reinforcing of gender roles between men and women in biomedical systems. Anderson and Taylor (2013) asserts that gender differences will always be concretized in social institutions and continue to shape men and women's experiences. As male participant, aged 29 years who took a child to the clinic explained:

"I was asked about the whereabouts of my wife for me to take a child to the hospital instead of the mother. I just lied that the mother was on her way coming. It was true those people (health personnel) needed to know where the mother was, for a man to take a child to the hospital."

Rabe (2014) explains that women are not only expected to give birth but to take care and raise those children. This is because women are confined to care-giving roles in the family and such social roles are specifically reserved for women gender. If a woman is not seen to perform such social roles, pressure emerge in order for her to conform to social expectations. When asked who wanted to know the whereabouts of the mother to the child, a 29 years old male participant pointed to a female nurse:

> *"It was a female nurse. She felt bad that a man was the one taking a sick baby to the hospital instead of a woman because she also knew that it was a woman's responsibility to take a child to the hospital."*

Since women are perceived as reproductive labourers and care-giving for the family falls under reproductive roles, women themselves are also seen to control and reinforce such reproductive and gendered roles through social surveillance in their families, social institutions and communities.

5.2.3 *Based on social class difference*

The majority of study participants felt that they were humiliated, insulted and discriminated against in public health facilities because of perceived social class differences. The social class position was in comparison with their education and employment status to health personnel who occupy working-class positions. However, this does not apply to other healthcare systems such as traditional and religious healing:

> *We (patients) are treated or cared rudely and sometimes neglected at the hospital because we (patients) are not as educated as them (nurse). We are not of the same social class. So they (health workers) don't look at us as full human beings (58 years old male participant).*

Another male participant aged 32 years old added:

> *"They (health workers) think that majority of patients who seek care from them are not as educated as they are. They (patients) are not working-class. So there's nothing we (patient) can tell them. But if you speak English or*

they know that this patient works in another ministry or any company, they tend to treat them well. One day I was at the clinic and a police officer came around 12hrs. He was not in police uniform. He didn't even queue up for the services. They (health workers) just saw him coming, they even went to welcome him and ushered him in the screening room, attended to and received drugs while us, who came early in the morning were still on the queue. Sometimes it could be a wife of a working-class man and if they know her. She won't queue up for the services. Sometimes these health workers drink beer together with these people, party together, and for such people when they come for services, they will be number one to be attended to. And you will never hear such people complaining about the poor services offered at these public clinics. These things are happening. We have experienced it, we see it happening."

Paynton (2008) claimed that institutionalize power and ultimate authority given to health practitioners on medical decision are based on outdated healthcare model. In trying to understand the provider-patient relationship, scholars have argued that there is power struggle, imbalances and hierarchies that makes a provider directing patients on medical treatment and the patient takes a subordinate role (Molina-Mula, 2018; Paynton, 2008). For instance, a nurse-patient relationship is characterized with power struggle (Jewkes, et al. 1998), and where there is power, there is always resistance (Molina-Mula, 2018). Jewkes, et al. (1998) further states that nursing practices is strongly characterized by humiliation and physical abuse of patients. In order for nurses to claim their authority, respect and class position, they verbally coerce, humiliate and sometimes physically abuse their patients. When patients resist, they are seen as undermining the authority and social status of a nurse, thus they (nurses) become entangled in continuous scuffle to reassert their class identity by creating social distance from patients (ibid.).

Some participants also reported that the type of disease also attract stigma, humiliation and abuse from biomedical providers, which is not the case in other healthcare systems (traditional or religious system). It was reported that there was no confidentiality and social support in the manner in which certain services were provided in biomedical healthcare systems. As one participant, aged 27 years reported:

"I was recently diagnosed with HIV/AIDS and I am current on Antiretroviral Therapy (ART). Sometimes it is quiet frustrating and embarrassing. Sometimes there are long queues at the hospital and you may not know a queue in which you are supposed to join. Those health workers, once they find out that you are in a wrong queue, they start shout at you. I was shouted at, scolded. That nurse just told me in front of people that I was supposed to join the queue where all ART patients are queuing up. That was embarrassing and I was upset. She just disclosed my HIV status and everyone now started looking at me. I was ashamed."

Several studies have found that social stigma and discrimination lead to high patient dropouts, avoidance of healthcare services and non-adherence to treatment especially for mental and HIV patients (D'Anna, et al. 2018; Mwamba, et al. 2018). The findings of this study can be linked to the findings from a study conducted in Lusaka by Mwamba et al. (2018), which shows that stigma, lack of confidentiality and social support for people living with HIV leads to avoidance, non-adherence and sourcing of alternative HIV treatment.

5.3 Perception and use of healthcare systems

5.3.1 Biomedical

Public health facilities

Wade and Halligan (2004) argue that the biomedical model of understanding and diagnosing illness has failures and cannot elucidate many forms of illness because of the assumption that all illness stems from a single underlying cause – that is disease (pathology), and attenuation of the disease result in health restoration. Such assumptions therefore, results in disbelief of patients or assigning wrong diagnosis for patients who present with illness without any disease indication (ibid.). These failures may also stem from poor clinical practices (Walshe & Shortell, 2004), shortages of drugs; and sometimes incompetence, not fully skilled to undertake a medical procedure or fail to adhere to their own good practices. In this study, participants indicated that biomedical healthcare system is a system that has also failed to give good outcomes or cure certain conditions:

"Sometimes I combine herbal medicines and conventional drugs to get cured quickly. But sometimes, the use of herbal medicine is as a result of

failure of conventional medicine to treat certain diseases. That's the main reason why after I try biomedical services and if there is no improvement, I end up seeking care from traditional healers or make my own herbal medicines."

The failure of biomedicine results in patients having to use their own agency and this leads to them combining or using traditional herbal medicine or completely abandon conventional medicine. Similarly, the findings from a study conducted in Nairobi, Kenya by Mothupi (2014), who found that women who had access to public healthcare system were concomitantly using herbal medicines and conventional medicine for management of same pregnancy condition or illness. In most cases, these practices by patients are done without the knowledge of health personnel for fear of being scolded, humiliating and neglected as traditional medicine has been blamed for health calamities (Bwalya, 2018).

This study also reveals that some people who first visited biomedical system before going to other healthcare systems or providers perceived biomedical systems as diagnostic centres where diseases are detected. Thus, people who were visiting public hospitals or clinics wanted to know the type of disease they were suffering from:

"I start going to the clinic so that I know the disease I am suffering from. I do this, especially when my child is sick because children do not talk. For fear of giving a child wrong medication, I start going to the clinic so that I know the causes or type of disease. Moreover, the services are also free of charge"

Experiences of Birthing Women in public healthcare system

Numerous studies have described women's birthing experiences in biomedical system as frightening, depressing, uncertain, lonely and violent (Chadwick, 2018; Shabot, 2016; Hastings-Tolsma et al., 2018; Jewkes, et al., 1998; Mwamba, et al., 2018). Many scholars have attributed to highly medicalization of birthing process and biomedical construction of patients as passive objects awaiting instructions concerning their medical condition (Shabot, 2016; Chadwick, 2018). Just as the patient is expected by clinicians to be passive, immobile and waiting for instructions, any movement or body expression results in actions or sanctions that bring conformity to medical instructions and demands. Women who participated in this study reported experiences of humiliation, negligence, emotional and physical abuse at the hands of midwives. When asked to state at which point of service

delivery were they abused, majority of women pointed to the time of pregnancy, labour and delivery. They explained that midwives expected patients (pregnant women) to behave in a certain way and conform to their demands and instructions and if they did not, then they were subjected to abusive language and other emotional abuse. As a female participant aged 37 years narrated:

> *"When labour started I went to the clinic where they did the examination and I was told that it was a bleach presentation meaning that the legs of the baby comes first before the head comes out. So, I was referred to the next level hospital. The female midwife I found on duty was good and she told me that the baby was going to be delivered like that, instead of rushing to theatre for caesarean. But the other female midwife who reported in the next shift was rude. She just came to my bed, took a patient's file and started asking me questions as if I was the one dictating what they should do. "How come you came at 10hrs but you haven't delivered yet", she asked me. "Why haven't they conducted a caesarean? Didn't they know that it was a bleach presentation?" I did not respond when she was talking. That same midwife was in-charge of maternity ward, so other nurses were afraid of her. Other midwives wanted to try other methods instead of caesarean and I was of that idea. That midwife (the in-charge) just came and told me that they were taking me to theatre because I was not following their instructions. Why are you pushing the baby? She asked me while shouting. "You don't listen," she told me.*

What did she mean when she told you that "you don't listen"? (Asked by researcher).

> *Because when the baby was trying to come out, I was also pushing. If I start crying because of labour pain, she (in-charge) would come and threaten me, telling me that she was going to take me to theatre for caesarean. Even when I changed my facial expression because of pain, she would tell me why I was doing that. Later on, she instructed other nurses to take me to theatre. Fortunately, there was a queue at the theatre room, and as I was waiting, the baby came out. So when she found that my baby was out, she started shouting at and insulting. She told me that I was stupid and my child*

was going to die. I became annoyed and I finally responded. It became too much. I told her off."

Another female participant aged 39 years added:

"From my own experience, the problem of shouting and insulting patients is common at the hospital. I escorted my neighbour who was pregnant to the hospital for delivery. I was shocked at what happened. In delivery room, a patient was crying due to labour pains, a nurse shouted at her and told her off, that they (nurses) were not there when they were having sexual intercourse for her to be pregnant."

Women's accounts about their birthing experiences explain how health personnel inflict additional pain and try to deny women's chances of exercising their agency during labour and delivery. According to Chadwick (2018), women and girls in labouring and delivery enter in self-silencing and censor their expression and actions in order to avoid abuse from health personnel. Chadwick's analysis of the experiences of birthing women provides an insight into such medical practices of silencing and muting women's voices are underpinned by medical beliefs that birthing women and girls have no knowledge, authority or status to define or interpret their own bodily experience during birthing process (ibid.). Studies have shown how women adopt a "hesitant, docile, silent body as a way of avoiding mistreatment" (Chadwick, 2018: 109; Shabot, 2016: 245). At every stage of labour and delivery, health personnel (doctors, midwives and nurses) ensure that they are in control, directing the process and expecting birthing mothers to lie passively and only respond or acts when they are told to do so. Thus, it is evident that the entire birthing processes is appropriated. However, in all these difficulties and humiliating situations, women resist, and sometimes express their emotions or opt to remain silent. Women's resistance and agency have been captured in the above quote (from female participant aged 37 years). Due to violence experienced by birthing women at the hands of midwives, this study found that there is a strong impetus for women not to give birth in health facilities especially in hospitals due to its medical violence.

Male midwives vs female midwives

Given the gendered and patriarchal context of Zambia, fleshed out in the opening chapter of this dissertation and the findings above, it is perhaps surprising that the study has found that male midwives were calm, respectful and paid attention when assisting women during

labour and delivery. Women explained that male midwives were respectful, not rude or forcing them and were not shouting at them during birthing. In a study conducted in four provinces of Zambia by Bwalya, et al. (2015) regarding the perceptions of pregnant women towards male midwives, the study shows that there was increased levels of acceptance of male midwives (83%), who also indicated that both male and female midwives received the same midwifery training, thus offered the same care, and that has led to increased institutional deliveries (CSO, 2007). In this study, women pointed to calmness, respect and rarely being scolded by male midwives:

> *Majority of male midwives or general male nurses are good and calm. They (male nurses) know how to take care of patients and how to talk to patients. But some female nurses are rude. They (female nurses) shout at patients, humiliating and use bad language.*

Another female participant aged 39 years old added:

> *"From my own experience, the problem of shouting and insulting patients is common at the hospital. I escorted my neighbour who was pregnant to the hospital for delivery. I was shocked at what happened. In a delivery room, a patient was crying due to labour pains, a female nurse shouted at her and told her off, that they (nurses) were not there when they were having sexual intercourse for her to be pregnant."*

Despite male midwives being part of a gendered and patriarchal script of Zambian culture, it was not clear why male midwives showed minimal patriarchal power relations when assisting birthing mothers. Although women interviewed accepted the care provided by male midwives because they needed help at that critical moment of labouring and delivery, and not concerned about the gender of a midwife, their preference of male midwives is due to the reasons started above. Similarly, the findings of a study conducted in South Africa by Mthombeni et al. (2018), which revealed that postpartum mothers preferred male midwives because they were seen as sympathetic, respectful, caring, patience, courtesy and promptly responded when complications arose unlike female midwives who were ignoring and shouting at patients when they were called.

Private health facilities

Several studies about health provider-patient relationships, perception and use of health facilities have been conducted in public health facilities (for example, Mwamba, et al. 2018; Mthombeni et al., 2018; Bwalya, et al., 2015; Jewkes, et al., 1998), and little is known about the provider-patient relationships in private health facilities. In this study, my informants interviewed indicated that they did not see any difference in the operations or the way patients were treated in private health facilities from public health facilities except that in private health facilities, providers were respectful, engage patients by allowing them to ask questions, and services were quickly provided as 26 year old male participant indicated:

> *"In private health facilities, people are treated with respect and services are provided quickly. You know, that is business so providers have to be friendlier in order for them to attract customers."*

Van den Heever, et al. (2013: 110) argue that during health professional trainings, emphasis is put on "politeness, kindness, pleasing, socially and professionally appropriate rather than to be genuine and congruent in their relationships with themselves and their patients." By allowing patients and their family members to ask questions about treatment procedures and outcomes, health providers become mindful about patient's autonomy in decision-making process (ibid) and teamwork and openness needed in healthcare (Molina-Mula, et al., 2018; Eliassen, 2015; Paynton, 2008).

Drug stores

Just like in private healthcare facilities, participants noticed that patients were given respect, and providers were friendly. Study participants also reported that providers were polite and services were quickly provided.

> *"Just like in private clinic, medical peddlers always treat patients well. You know, that is business so they have to be friendlier in order for them to attract customers."*

Although no physical examinations were conducted, medicines were sold based on the prescription obtained mainly from public health facilities. In this health setting, providers were also selling medicines to patients based on explanation of the signs and symptoms of the

disease as well as to those who went direct to make a request or name the drugs they were looking for.

5.3.2 *Traditional healthcare system*

It is well documented that people have strong and positive perception about traditional healthcare systems (Mothupi, 2014; Bwalya, 2018). People's positive perception about traditional healing has been associated with long history of use and its safety (ibid.). In this study, participants who visited traditional healthcare system or providers felt that traditional health system could cure diseases that other health systems did not. However, just like in any other health systems, people's traversed journey in search for healing confirmed treatment failure in all healthcare systems:

> *"After several attempts seeking care from public hospital, there was no improvement in the condition. My wife's condition kept on deteriorating. So we decided to go and seek care from traditional healer. We started thinking that the problem might be caused by witchcraft or evil spirit and that's how we took her to a traditional healer where she was admitted and later on, she started feeling well."*

The study also found that treatment failure associated with certain disease prompt people when confronted with the same disease to seek care from where they were cured before. This study shows that biomedical healthcare system was the second or last option where people can seek care from:

> *"Sometimes I also know that this type of disease cannot be cured at any health facility and that prompts me to go to traditional healer or make my own herbal medicines. Unless I try my own traditional medicine and if it cannot work that's when I think of going to consult from other people within my community before I go to these known traditional healers. Then if traditional healers fail to treat me that is when I go to the hospital."*

When traditional healers fail to treat certain diseases or if the patient is not getting better, they ask their patients to seek care from health facilities:

> *If traditional healers fail to manage or treat illness, he/she will ask a patient to go to the hospital. Unlike medical personnel, once they fail to treat a condition, they discharge a patient even when they know a person is*

still sick. So, it's one way of indirect telling a patient that they have failed and you need to look for other means of treatment.

This is similar to the findings of the study conducted in Kenya by Mbwayo (2013), whereby traditional healers were referring their patients to the hospital if they fail to treat or if patients are not getting better. In Ghana, traditional healers were asking their clients to go to the hospital for medical diagnoses after treatment to confirm that they are cured as one way of assuring clients of their credibility and ability to cure diseases (White, 2015: 3).

Experiences of Birthing Women in tradition healthcare system

In Zambia, more than half (52%) of births occur at home, outside established health facilities (CSO, 2007), and these births are assisted by traditional midwives (Sialubanje, et al., 2015). Although the changes in the Zambian reproductive health policy resulted in the banning of traditional midwives from conducting deliveries; both those (TBAs) previously trained by Zambian Ministry of Health and those who acquired delivery skills on their own and through apprenticeship (MoH, 2000), studies also indicate that women, especially those in rural communities still give birth at home with the assistance of traditional midwives (Muzyamba, 2019; Cheelo, et al., 2016; Sialubanje, et al., 2015). Thus, the action taken by the Zambian government to outlaw the only alternative obstetric care – that is traditional midwives - for women who may not have access to institutional skilled midwives seems to be contradictory on what is happening on the ground (Muzyamba, 2019). A good number of Zambian women prefer home deliveries with the assistance of traditional midwives (Sialubanje, et al., 2015; CSO, 2007). Nonetheless, there are several factors that hinder women from giving birth at health facilities, these include among others factors; accessibility, distance to health facilities, cost and other requirements (baby clothing, lotion, food while admitted at health facilities) (Sialubanje, et al., 2015; Bwalya, 2018; Ettarh & Kimani, 2014). However, several studies have also pointed to provider-patient relationship, as the reason women prefer traditional midwives and home deliveries to institutional deliveries (Mathole, et al., 2004; Sialubanje, et al., 2015; Letamo & Majelantle, 2001). In Zimbabwe, Mathole, et al. (2004) described nurses assisting women to give birth as rude, unfriendly, lack of respect and use abusive language. However, in this study, I found that health workers who were in rural health posts were actually more respectful than the health workers at central hospital were. This shows that the least hierarchy between the rural health

nurse and the community who she/he lives with, the better treatment, rural health post nurses treat patients with respect, similar to the ways traditional healers treat their clients with respect. Therefore, there is a strong impetus for people to go to the clinic/health post, but the hospital is a least place to go because of its hierarchical and least human communication. Thus, people try everything possible to avoid going to the hospital.

The preference of traditional midwives to institutional midwives has been attributed to positive perception about traditional midwives and have been seen as skilled, trustworthy, respectful, friendly, offers better maternal and child health services, and always available when needed (Sialubanje, et al., 2015; Letamo & Majelantle, 2001). Similarly, this study found that traditional midwives treated birthing women with respect and there was calmness during labour and delivery. As one participant aged, 32 years explained:

> *"They used to be traditional birth attendants (TBAs) who used to help women during birthing but the government banned them from conduct delivery services. Those (TBAs) were women selected from our communities to help pregnant women. They were good and calm during delivery. That is why we liked them. Once labour pains start, we used to call them and they would come at your house and conduct delivery without taking you to the clinic. We only used to go to the clinic for postnatal services. They were not charging for delivery services but sometimes we just used to give them gifts as token of appreciation and that was not mandatory but the government banned them."*

The study also found that women who used to seek care from traditional midwives were shamed, blamed and humiliated when they go for postnatal services at health facilities. This was because traditional midwives were seen as unskilled, incompetent and contributing to maternal and neonatal mortalities. On the contrary, women reported that even when they give birth in health facilities, their babies die and health personnel still blame them for not consistently attending antenatal care, reporting late for delivery, and not following instructions during birthing process and accused them of using traditional herbal medicine during pregnancy.

5.3.3 *Religious healing system*

The study found that men and women were using religious healing system because of their beliefs about supernatural powers. Puchalski (2001: 354) states that "religious convictions may affect healthcare decision making." Numerous studies have pointed out the importance of religious beliefs and practices and its influence on patient healthcare seeking behaviour and curative (Isaac, et al. 2016; Puchalski, 2001). Patient's religious beliefs may enhance recovery, coping with illness and pain (Puchalski, 2001). However, some religious beliefs may inhibit healthcare seeking and hinder adherence to treatment (ibid). Similarly, this study found that despite patients not given any medication during healing processes, they continued going for healing prayers because they believed that there was no disease that can be cured without God's interventions. Patients also strongly believed that the combination of prayers and medicine could enhance coping strategies with disease and ultimately result in good health outcome. As one participant aged, 46 years explained:

> *"I go for healing prayers because I believe there is no disease that God can fail to cure. If I am using medicine and I am also praying to God. God does not fail. He cures all diseases that is what I believe in. First, I started going to the hospital so that I know the condition/disease I am suffering from, and receive medication. Then I go for prayers or I ask a religious healer to come and pray for me."*

The study also found that people were seeking care from religious systems because services were free; no discrimination and religious healers politely communicated with them. Although healing services were offered free, some participants reported that they were told to buy anointed water from religious healers, which they were using to perform religious rituals. The use of anointed water as a form of medicine is not unique in this context. In the study of traditional medicine in modern Zimbabwe, Chavunduka (1994: 25) found that religious healers "rejected both traditional and Western medicine, which they replaced with blessed water (commonly known as anointed water) and other symbolic objectives."

Although patients were not required to pay for services, it was reported that some religious healers were selling anointed water to their followers. Giving gifts to religious healers also characterized religious ceremonies. Nonetheless, the majority of participants felt that religious healing does not cure disease but it only gives hope that God protects and cures all diseases through people's faith and prayers. Because there was no medication given during

religious healing sessions, patients believed that prayers alone could not cure diseases. Therefore, religious healing requires a combination of treatment from other healthcare systems, as 29 years old male participant indicated:

> *"Prayers alone do not cure. Thus, religious healing requires a combination of other treatment and it's only at the hospital and from these herbalists where a person can be healed."*

Another male participant aged 32 years added that:

> *"I only had faith that once he (religious healer) prayed for me I was going to be healed. Religious healers have divine powers. They communicate with God. A doctor can give you medicine but medicine cannot work alone, you need prayers for you to be healed."*

Thus, it was these reasons that made religious healing the last option for people and participants believed that healing prayers could not work without medications. Clements (1981) states that religious healing is characterized by treatment failures. However, religious followers believe that prayers save the sick and heal their bodies and mind.

Summary of the key findings presented in chapter

This examination of the interlinking segments of the health setting with household gendered power dynamics, in Zambian life combined with the specific experiences of clinical, traditional, household, private and religious healing sources of my participants in this study, form the basis for this summary of the finding. The study found various factors influencing men and women's actions as they seek care in a plural healthcare system where different forms of healthcare systems exist. In this study, the complexity of household, and health seeking behaviour blended with people's resources and agency, play a key role in defining and determining health opportunities, expectations and health needs. Suffice to say that, the power dynamics that exist at household level (husband verses wife) in terms of decision-making, greatly influence peoples' actions about healthcare choices and expectations. Other factors include; the type of disease, past experiences with healthcare system, social networks, distance to healthcare system and cost involved in accessing the services determine people's choices and use of healthcare systems.

The study further found various forms of healthcare systems, which can be categorized into; biomedical; traditional and religious healing systems with different providers and

practitioners tied to or practising in line with different health systems. The availability of different forms of healthcare systems provides health opportunities and result in complex journey undertaken by women and men in this region as they seek health and healing.

However, these different forms of health systems are not grouped together on an even plane: various government policies and laws isolate some health systems and practitioners such as traditional systems and traditional midwives. This scenario results in the policing of traditional healing systems, shaming and blaming of people who seek care from traditional systems. Despite such interventions put in place by the Zambia government to isolate traditional healing system, people find the system useful, and pointed out various reasons that attract them, such as; trust in herbal medicines, calmness and respectful ways in which they are taken care of by providers. For birthing mothers, traditional midwives provided free services and there was calmness and respect during birthing process. Although, traditional systems attracted people, the costs of services and treatment failure made people to quit and seek care from other systems and providers.

The study found men and women having access to free primary healthcare services in various government health facilities. These government health facilities co-exist with other forms of biomedical systems such as private clinics, drug stores and other private providers trained and licensed by the state. These private healthcare systems and its providers were seen as supplementary to public healthcare systems. Although, services were provided free of charge in state health facilities, people of this region reported shortages of drugs/supplies, treatment failure, institutional procedures and toxic human interactions as the main reasons why they opted out of the system. For private health services, cost of accessing the services, treatment failure and sometimes distances to the facilities, hindered access to privatized services. However, quick service delivery, calmness and politeness of providers attracted people in private biomedical systems.

The existing health systems are embedded with Christian elements and people of this region believe in divine powers in healing processes. Thus, majority of people frequent religious healing systems and others calling for divine interventions whenever they are sick. Despite reports that there was no medication or examination conducted to determine the type of diseases or treatment methods, people were seeking care from religious healing system because of their strong spiritual conviction, which enhances the coping strategies with illness and pain. Unlike other health systems, in religious healing, there was no medication or any

other treatment methods given, apart from “anointed water.” For this reason, the study found that religious healing system was the last option from which people seek care because people believed that prayers alone could not cure the disease unless combined with medication. However, people also believed that there was no disease that could be cured without God’s interventions. In order to show the spirituality, some religious healers were giving patients “anointed water” as a form of medication, and protection from evil spirits.

CHAPTER 6. IMBRICATION, EXPERIENCES AND NEW PATTERNS OF HEALTH SEEKING BEHAVIOUR

6.1 Introduction

This chapter focuses on the key research findings, and summarises the findings, and gives recommendations. This study envisaged to investigate the social relations of power, stigma, and discrimination linked to gender, class, age and other forms of inequalities in healthcare provisions and the agency of Zambian people in seeking health.

As discussed in the previous chapters, women and men in the Eastern region of Zambia travel a complex journey in search of their health and healing, thus resulting into an imbricated pattern of medical knowledge, health systems and health seeking behaviour. Consistent with the social construction theory, which states that "all human activity is subject to habitualization" (Berger & Luckmann, 1966: 70). This suggests that any action performed, may be repeated in the future in the same way, with the same economy of effort, thus making it unnecessary for each situation to be defined anew, henceforth any action to be undertaken can be anticipated (ibid. : 71). Adopting the ideas of social constructionists, it is asserted, in terms of habitualization, that any frequently repeated human actions become cast into behavioural patterns that is reproduced with the same effort (ibid.), as this chapter demonstrates the imbricated patterns of health seeking behaviour, medical knowledge and practices, complexities and experiences of illness and medical encounter in a plural healthcare systems.

6.2 Imbrication, experiences and new patterns of health seeking behaviour

This study demonstrate how ordinary men and women in one district of Zambia, with one hospital, are managing their health. In this study, I placed the household at the centre of analysis and traced people's journey in search for health and healing. Far from being ignorant, and without enough resources, and despite being vulnerable economically, I took the agency and health knowledge of the people of this region seriously. During my honours research project, I interviewed a woman and I had to follow her once again, and this is how she experienced healthcare during her pregnancy. She (a female participant aged 29 years old, interviewed in 2018, 2019) stated that:

> *"I took traditional herbal medicine so that I quicken labour and delivery. I used to go for antenatal care services but I wanted to deliver at home because I*

had no clothing, baby blankets, and lotions for the baby and sanitizers to use after delivery. I did this to avoid being embarrassment, neglected and vilified by nurses. So when labour started I called a traditional midwife who helped me deliver and later on I went to the clinic to have my baby registered."

The above narrative shows that poor rural people who have little money are making a quick and rational decision to choose health outcomes. This evidence inspired me to dig deeper and my findings are that these people are neither ignorant nor suspicious, and that they do not wilfully refuse to go to health facilities and be helped. It is the burden of the above kinds of medical requirements, hindering access to or distancing many vulnerable people, especially birthing mothers, from attending reproductive healthcare services – all to the detriment of already vulnerable people. The finding of this study is similar to other studies in Zambia (Sialubanje, et al., 2015) and outside the country (Morgan, et al., 2017; Jewkes, et al., 1998). Often times, when expectant mothers do not meet medical requirements, services are delayed and sometimes withheld. In biomedical healthcare, baby blankets, clothing, baby lotion, sanitizers and other requirements, are part of medical supplies (Morgan, et al., 2017) and these items are seen as medicine, hence they must be new. Besides, biomedical systems become platforms for modernizing people. When people are sick, and in need of care from health facilities, they have to look modern, thus the biomedical approach in service provision where birthing mothers are required to bring new medical supplies for the babies including their own clothes, during labour and delivery can be framed around metropolitan modernity.

It is through such narratives, and the eyes of this woman (*Female participant, interviewed 2018, 2019*) and many other men and women I interviewed that helped me to understand the regional health system, come up with the hypothesis and draw up the actual regional healthcare system, which is imbricated in its function, and illustrates people's experience and partners of health seeking behaviour. The diagram below illustrates the regional healthcare system that is inclusive:

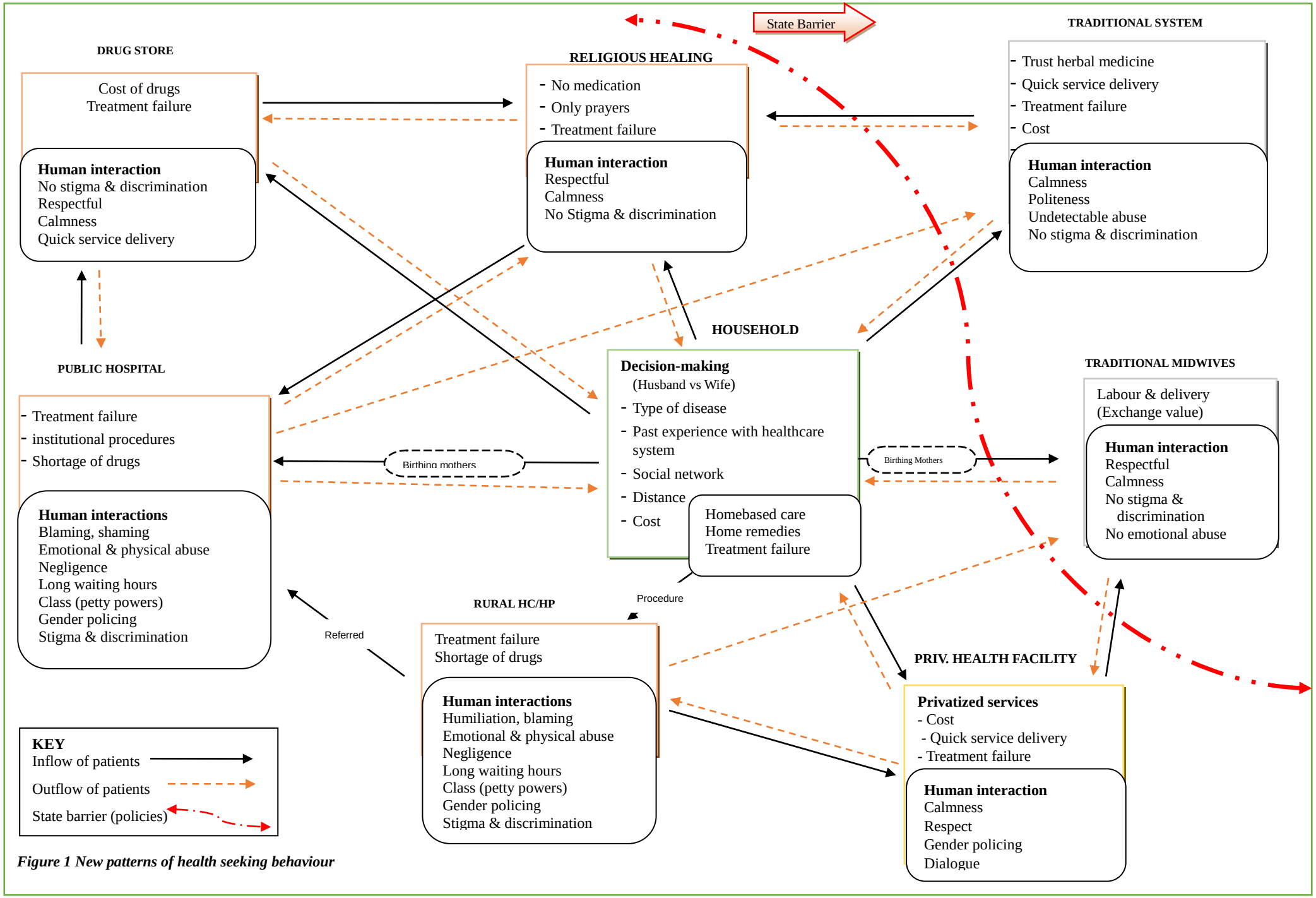


Figure 1 New patterns of health seeking behaviour

6.3 Household and healthcare choices

In this study, the household is placed at the centre of analysis. It is also a starting point at which people's journey in search for health, and healing begins. Household's health choices and outcome involves negotiations, not only limited within household but also includes social network. As Mkhwanazi (2018) states that decisions about healthcare choices is not a straightforward matter, but a process that involves negotiations among close friends and family members. Despite women carrying huge burden in child and family care (ibid.), they become invisible in household decision-making processes.

Patriarchal powers

The main concern here is the way in which patriarchal societies perceive and construct the relationship between men and women either in the household or outside. Men and women have been perceived and understood in terms of their opposition to each other (Perelberg & Miller, 1990), and various literature, institutions and practices play a key role in reinforcing these dichotomies, and gendered categories. The dominant position occupied by men in household, makes them to have control over women and assert themselves as sources of knowledge. Apart from patriarchal power relations that greatly influence decisions about household health, I found out that social network, past experience with healthcare system, distance and cost of services were also determinants of healthcare choices.

Social network

Evidence from the literature suggests that the definition, understanding, interpretation and decisions regarding intervention and health choices during illness involves an individual, a network of friends and families (Maluma et al. 2017; Mothupi, 2014; Soi & Keng, 2013; Booyens, 1991). It is within this social network that diseases are first experienced, diagnosed and treated (Booyens, 1991). These networks of friends and family members represent the social and cultural environment, which many studies point to as determinants of health seeking behaviour (Mothupi, 2014; Maluma, et al., 2017). In this study therefore, I found that social networks greatly influence household's decision about healthcare choices.

Type of illness

During interviews with informants, it emerged that people had knowledge to interpret the type of disease/illness and prescribe the treatment. Now depending on the type of illness (for example, coughing, headache, malaria, pneumonia, diabetes, etc.) and cultural beliefs, the

community in which people belong, produces its own medical knowledge about illness/diseases and anyone who feels alienated from the biomedical health system will use that knowledge when they are ill.

Past experience with healthcare system

It is undeniable fact that when healthcare choices are made, people use information based on their past experiences or encounter with health providers. Avoidance of care from certain health systems is highly associated with past negative healthcare experiences (Schwei, et al., 2017), which could be in terms of treatment failure or negative provider-patient relationship. Growing evidence from literature suggests that increased bullying, scolding and publicly humiliating patients by providers especially in public health facilities are linked to patient's decision to stay away or quite or nonadherence to treatment especially HIV patients (Mwamba, et al., 2018). However, patient's positive experiences of health system can be a pull factor. Sialubanje, et al. (2015), in their study about the reasons for home delivery and use of traditional birth attendants in rural Zambia, found that women's decision about place of delivery was influenced by their evaluation of comparative advantages of their delivering at health facilities or home delivery with assistance of TBA, with their decisions largely influenced by past experiences with the system. Similarly, this study found that past experiences greatly influence household healthcare choices.

Cost of services

Numerous studies have pointed to costs of services and accessing biomedical healthcare systems as hindrance to modern healthcare (Mwamba, et al. 2018; Sialubanje, et al. 2015; Ngoma, 2016) especially after privatization of healthcare systems. Although the study participants reported that provision of primary healthcare services was free of charge in public health facilities, this study established that there were hidden costs associated with access modern healthcare services. The cost of services in free public health facilities is associated with meeting requirements (especially for expectant mothers – who are required to carry medical supplies when giving birth) or cost of keeping oneself when admitted. Given the fact that many people cannot afford to purchase or meet additional cost, they opt to stay away or avoid seeking care from public clinics and opt for alternative care and that is traditional care. However, the study further established that even services offered by traditional midwives comes with monetary value as my informants reported giving gifts to traditional midwives after successful delivery of babies.

Distance to health system

Several studies have indicated that long distances to health facilities cost patient money and time, hence a barrier to accessing modern healthcare (Mwamba, et al. 2018; Sialubanje, et al. 2015; Ngoma, 2016). In this study, the majority of participants reported that all healthcare systems were within reach except in situations where they were referred, for instance from rural clinic to hospital or when they wanted to access privatized health services.

However, as the diagram above illustrates, the household is surrounded by different healthcare systems and health providers. These different forms of health systems and health-seeking behaviour produce their own knowledge, and people keep them in their verbal and oral memory and they share that knowledge with each other through social networks. Now depending on the type illness, past experiences, distance and cost, and anyone who feels alienated from any healthcare system use that medical knowledge when they are confronted with illness to choose the type of healthcare they are comfortable with or which they can afford. Therefore, when people make decisions, they are not drawing on ancient knowledge, they draw on contemporary knowledge produced by their communities and their different health systems that pushes against the general views held by majority people and available literature particularly about the health seek behaviour of people in rural parts of Zambia.

6.4 Barriers to accessing traditional healthcare systems

The above diagram (figure 1) also shows state barrier (red line) to accessing traditional healthcare. This state barrier is inform of state policies against traditional healthcare system and its providers. While the government sees other forms of health systems such as religious healing, medical peddlers, drug stores and private health facilities as complementary to public healthcare system, traditional healthcare system is viewed as a threat to general public health. Thus, I found out that the people who crossed state policies (red line) were blamed, humiliated, had their services delayed and sometimes withheld. As discussed in the previous chapter, these experiences were common for women who sought care from traditional midwives when they went for postnatal services at health facilities; they were blamed, humiliated, and scolded.

The state policies (red line) also represent coloniality of biomedicine. As early as 1914, the Northern Rhodesian government (today Zambia) enacted anti-witchcraft law (Witchcraft Act of 1914). This was as a result of the influence of early Christian medical missionaries who

associated traditional healing and practices with witchcraft and paganism; unscientific and urged the eradication or legal circumscribing of these, onto the colonial state structure, which still exist in Zambian postcolonial law to this day. While both early Christian missionaries and colonial state were busy isolating and appropriating traditional healing systems, they were at the same time promoting their own Western medicines (Kalusa, 2007; Simundengu, 1992). Thus, state policies and biomedical practices have posed a great challenge and have led to diminishing and decline of traditional healing systems.

However, in 1970s, the post-independent Zambian government through the Ministry of health developed the new reproductive health policy and incorporated traditional midwives into the mainstream healthcare system as a way of embarking on community-based service provision in an effort to promote safe motherhood and reduce the burden of distance to health facilities for birthing mothers (MoH, 2000). The World health organization also recognized the importance of traditional birth attendants (TBAs) in health service delivery at community level and called upon governments in resource-constrained countries to incorporate TBAs in service delivery. The government trained some TBAs while others were persons who acquired skills by delivering babies themselves or through apprenticeship (MoH, 2000; WHO, 1992). This created an imbricated pattern, not only in terms of medical knowledge but also in terms of the ways in which both biomedical midwives and traditional midwives performed their functions.

With the recent changes in the Zambian governments' reproductive health policy, traditional health system and practitioners such as traditional midwives have been isolated again through various government policies and laws. According to Sialubanje et al. (2015), these changes in reproductive health policies have resulted in isolating, and not recognizing traditional midwives as part of providers of essential obstetric care in Zambia. The continued isolation of traditional healthcare system and its providers contradict what is on the ground and how people experience healthcare systems. As the available evidence suggests, 80% of Zambian population is estimated to use or depend on traditional and alternative services for their healthcare (MoH, 2012), with over a third of women doing so during pregnancy (Maluma, et al., 2017). Despite the banning and disengagement of traditional midwives from mainstream public health, I found that people (especially expectant women) find traditional system useful, and pointed out various reasons that attract them, such as; trust in herbal medicines, calmness and respectful ways in which they are taken care of by providers.

6.5 Common features in healthcare systems

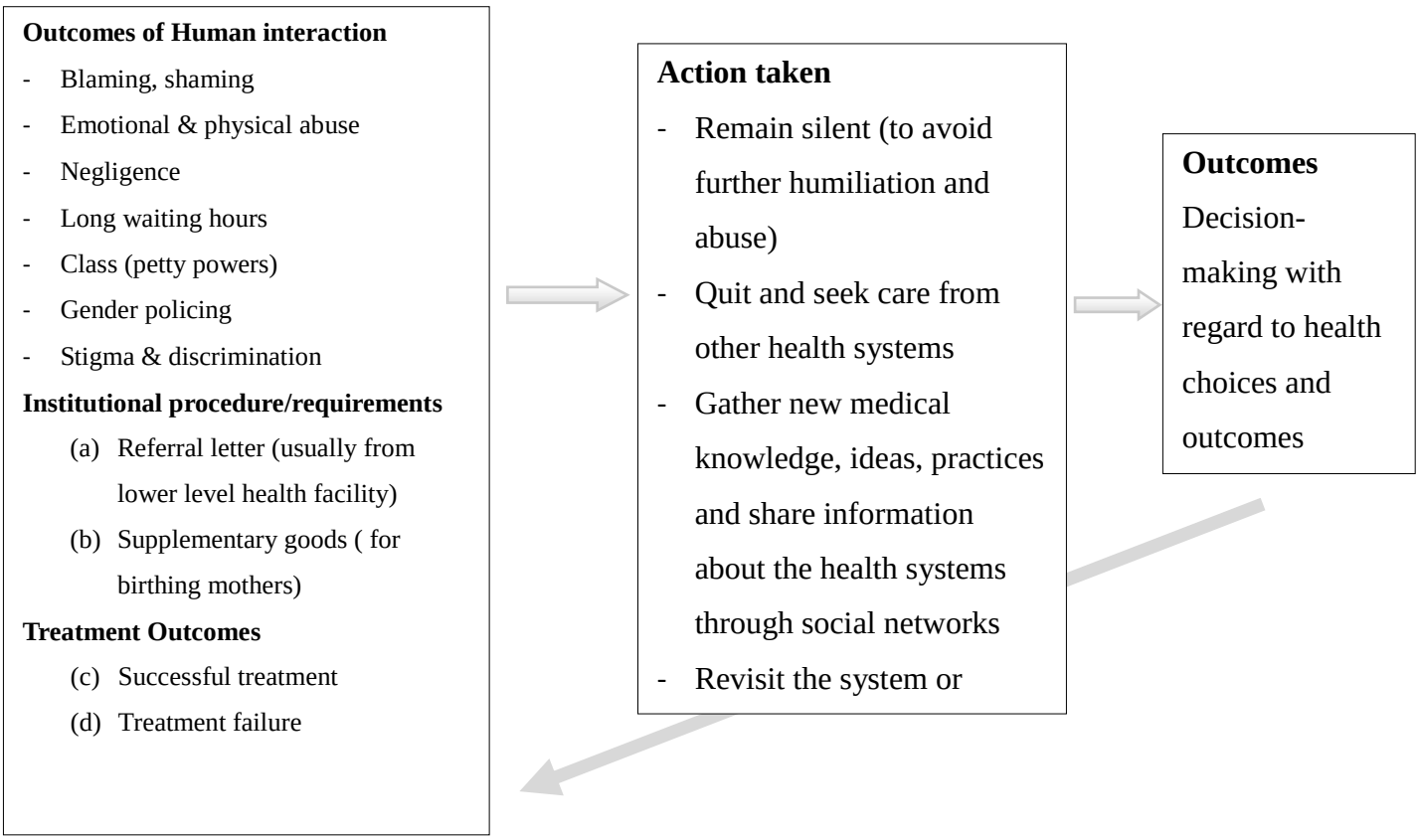
During interviews with my informants, I discovered that there are two common features commonly in all healthcare systems, namely human interaction and treatment failure. Firstly, human interaction was characterized by the involvement of the provider and patients. The interaction between health providers and patients, and the system itself, results in acquisition of new medical knowledge and practices that lead to interpretation of diseases, ideas and acquisition of new treatment methods. However, people's agency is influenced by both positive and negative human interaction and treatment outcomes. The positive human interaction and treatment outcomes attract people to the system. On the other hand, negative human interaction make people quit and seek care from other health systems. For example, the study found that one of the major reasons people were not using or deserting biomedical system was toxic human interaction that resulted in humiliation, emotional and physical abuse, clinical negligence, class positions (petty powers) and gender policing. Such outcome of human interaction results in people exercising their agency by remaining silent to avoid further abuse; and quit and seek care form other health systems. Again, as people negotiate these health systems, they gather and share information about the system through social networks. The information gathered influence decision-making about medical choices and outcomes. The actions taken by people demonstrate that people are not passive but have agency contrary to biomedical system, which perceive or expect patients to be passive.

Secondly, the other common feature is treatment failure. Treatment failure happens in all healthcare systems. The failure by the provider/s to adhere to treatment procedure/s or practices or medicine itself can lead to treatment failure. Sometimes traditional healers fail or biomedical providers give wrong medication, or sometimes the hospital/clinic may not have medicines, and nurses fail to follow simple procedure/s because they are overwhelmed or not fully skilled to undertake a medical procedure or failure to adhere to their own good practices. All these may result in calamities in health systems and practices. Thus, people draw on that knowledge of failure and their decision is not based on ignorance. Since all healthcare systems produce their own knowledge, ideas and practices, people drawn on that contemporary knowledge and not ancient knowledge to make decision about health choices and outcomes.

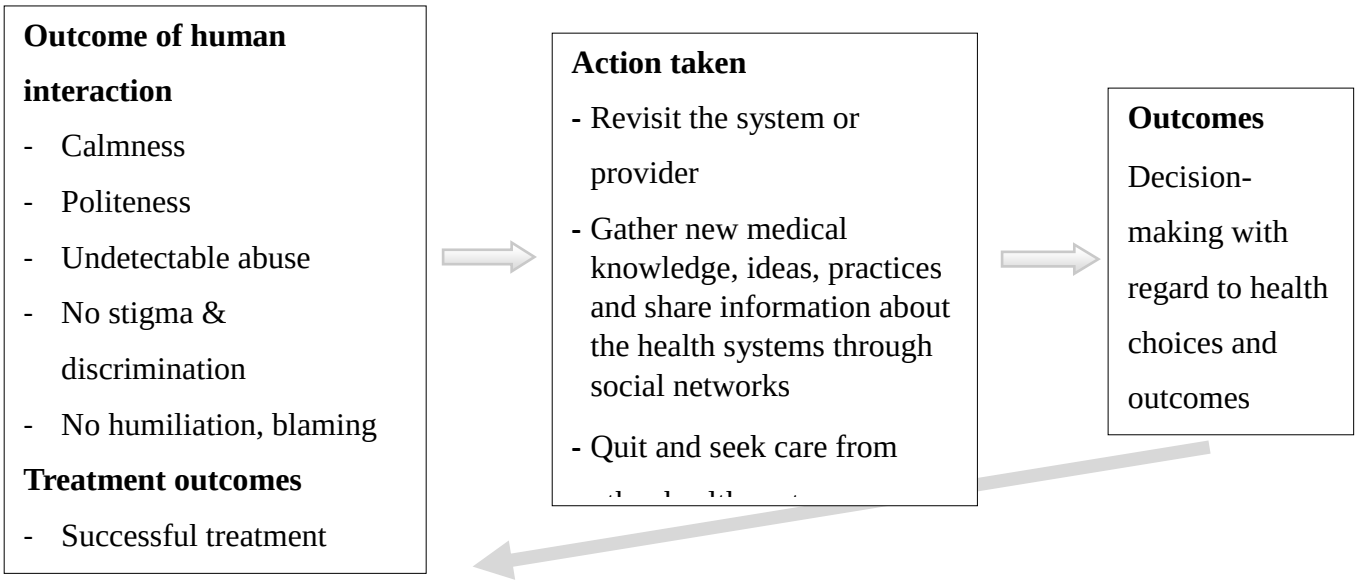
6.6 How patients exercise their agency

Below are illustrations of how people exercise their agency. First, the outcomes of human interaction, institutional procedure/requirements and treatment outcomes make people to take actions. Thus, their future decision about health choices will be made based on their experiences with the system, medical knowledge, ideas and practices acquired, and information gathered during their visits to health systems.

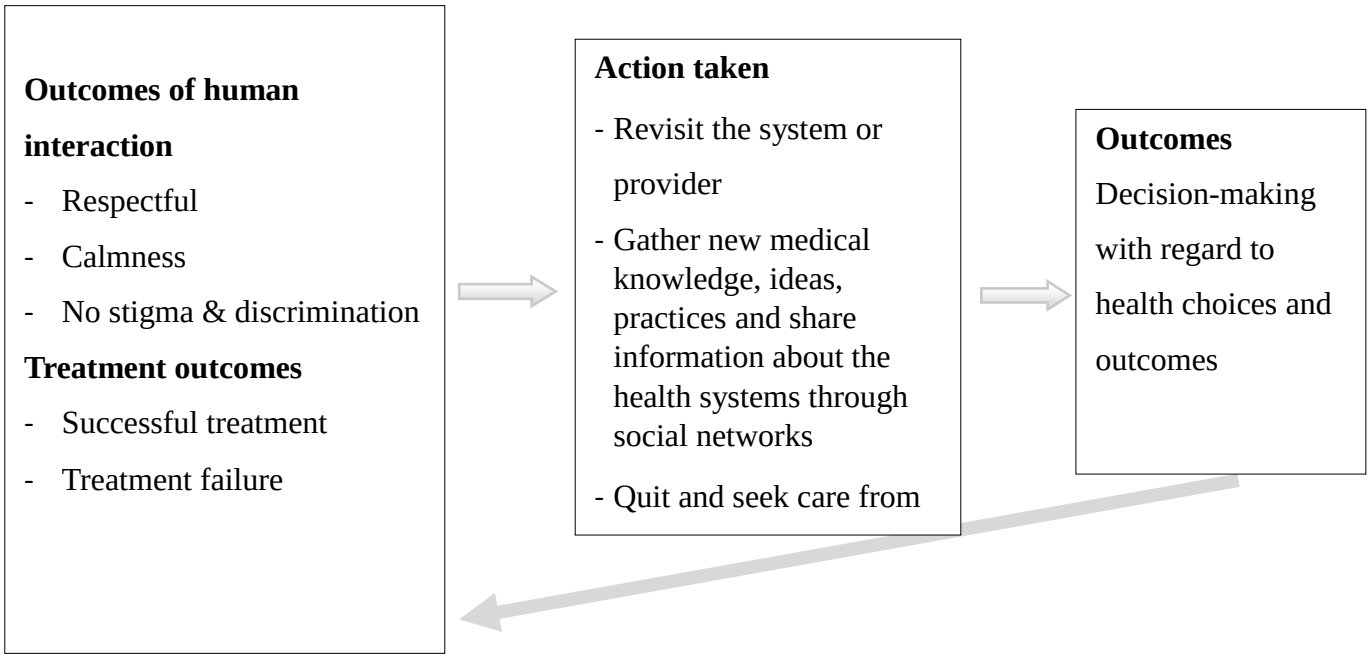
6.6.1 Biomedical healthcare system



6.6.2 Traditional healthcare system



6.6.3 Religious healing system



Summary of this chapter

This chapter demonstrated the complexities, experiences and imbricated patterns of health seeking behaviour, medical knowledge and practices in a plural healthcare system. It also shows the actual regional healthcare system as people experience it. In a plural healthcare system, people draw on different medical knowledge, healthcare systems, health providers and they see all these as available treatment options. As people navigate these health systems, their health seeking patterns and behaviour change due to acquisition of new medical knowledge, ideas and practices that lead to interpretation and treatment of diseases. Thus, by taking actions the people of this region, demonstrate agency in their health practices, and their health seeking behaviour and actions are adjusted in an effort to facilitate their wellness.

6.7 Conclusion and Recommendations

The four key points emerged from this study, nested within the layers of the contemporary medical system. Firstly, it emerged that patients seek care across various health systems and health practitioners equally integrate certain elements and practices of other forms of healthcare systems. Secondly, people see the availability of different forms of healthcare systems as available treatment options. Thirdly, people (especially pregnant women) mix biomedicine, traditional medicines, religious healing and seek care across health systems, seeing this as an effective way of treating certain ailments. Finally the integration of

traditional midwives in the mainstream public health system (from 1970s to late 2000s) by the Zambian government (MoH, 2000; Sialubanje, et al., 2015) is analysed here and is a clear indication of how healthcare systems, medical knowledge and practices are imbricated. This study shows throughout how the people of Eastern region of Zambia employ multiple strategies and draw on many resources and forms of knowledge in pursuit of available treatment options. Thus, their search for health and healing, and their health seeking behaviour, is neither simple nor teleological.

The complexity of household's health-seeking behaviour blended with people's resources and agency, and multiple dominant factors such as gender, social class and age, helped to define and determine health opportunities and health outcomes. It also emerged in this study that as people navigate various forms of health systems, their health seeking patterns and behaviour change, forming imbricated patterns, due to acquisition of new medical knowledge, new ideas and new practices. Thus, by taking action during illness and interacting with health providers and the system itself, people of this region demonstrate energy and agency in their health practices. Their health seeking behaviour and actions are adjusted in an effort to facilitate their wellness.

Recommendations

Therefore, this study recommends the following:

- Given the gendered and patriarchal context of Zambia, it is perhaps surprising that male midwives are perceived to be gentle, calm, and respectful and pay attention when assisting birthing women, and this may suggest more need to explore this theme.
- In addition, nurses who work in rural health posts – who have more autonomy over their work regime and less hierarchy above them on a daily basis – are perceived to be more respectful than the nurses who work at central hospitals; again this theme about identification of rural based nurses more readily with the community they serve compared to more urban-based nurses, also warrants the need to conduct studies to determine the reasons nurses behave differently in different places and spaces.
- Given the changes in reproductive health policies that has resulted in isolation of traditional midwives, current state polices contradict what is on the ground and how women experience the healthcare system. Also given the increased use of traditional

and other complementary medicine (80%) by Zambian people (MoH, 2012), this findings of this research suggest that relevant authorities need to reconsider the integration of traditional midwives and medicines in public health services. This could not only improve community-based healthcare services and promote safe motherhood but also reduce the burden of distance to health facilities and costs in access modern healthcare systems. In addition, evidence suggests, economic values in the practice of traditional medicine. Countries that have developed and refined traditional medicines have made billions of money. For example, a WHO (2008) report indicated, China made $14 billion, Western Europe $5 billion and Brazil $160 million.

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APPENDIX A: Interview guide

1. Section A: Background Characteristics (both Men and Women)

Please tell me the following about yourself:

1.1 Age

1.2 Marital status

1.3 Highest level of education

1.4 Employment status

1.5 Income level

2. Section B: Types of healthcare services visited (both Men and Women)

2.1 In the last two years, have you ever visited or seek care from any of the healthcare providers? If yes, which healthcare provider did you visit or seek care from?

(a) Traditional healer or herbalist

(b) Religious healer

(c) Biomedical provider (public or private)

(d) Medical peddler

(e) Or homebased care

2.2 What made you to go and seek care from these providers? Please give the reasons. Probe on cost, type of illness, convenience or social linkages.

2.3 If you or any member of your family is sick, where are you likely to go first and seek healthcare services? Give reasons. Probe on types of healthcare.

2.4 Who decide where to go for healthcare services? Is it yourself, your partner, or any member of your family or friend? What is their gender (Male or female)? Explain the reasons

2.5 What determines the type of services you want to receive? Is it your finances, cost and availability of services or location? Please give us any other reasons.

2.6 Describe your experience of visiting or seeking care from these different healthcare providers? How were you treated or communicated to by these providers?

2.7 What are the differences or similarities in the manner in which you were treated or communicated to by these providers?

2.8 Do you think someone of different gender, age or socioeconomic status would be treated or communicated to in a different way as they did to you? Please explain.

2.9 When you visited these healthcare providers, how long did it take you to be attended to? Please explain why.

2.10 What made you to leave this care provider or facility and seek healthcare from another provider? Explain the reasons.

3. Section B: Communication in healthcare systems (Women Only)

3.1 Do you remember how many times you visited a health facility or healthcare provider for reproductive health services? For instance, when you were pregnant?

3.2 At what stage of your pregnancy did you seek care from each provider? Explain why? Why did you or did you not visit or seek care from biomedical, traditional, religious or homebased care at this stage?

3.3 Did you feel free to talk to healthcare provider about how you were feeling? Explain why?

3.4 How were these different healthcare providers communicated to you? Explain the reasons why they communicated to you in that manner?

3.5 Did they respond or talk or listen to you when you explained to them how you were feeling? In a positive or negative way? Explain why?

3.6 At what stage of your pregnancy for instance, do you think you were treated well or not well by different providers, you visited? Give the reasons.

3.7 When you were in pain and told the healthcare provider, did they pay attention to you or did they just ignore you? Explain why?

3.8 Did you decide the type of services you wanted or did healthcare providers consult you before providing the services or given you the options for treatment? Explain why?

3.9 Did you have the freedom to decide if, when and how you want the services to be provided? Explain why?

End of interview

Thank you for participating in the study

APPENDIX B: Information Sheet and Informed Consent

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Departement Sosiologie/Department of Sociology
Fakulteit Geesteswetenskappe/Faculty of Humanities

Information and Consent Form

Dear participant.

My name is Wilson Bwalya. I am a Masters student in the Department of Sociology at the University of Pretoria. I am carrying out a study on "The Search for Healing and Health in Zambian Eastern Province: A sociological investigation of imbricated systems". This study will also seek to understand the experiences of both men and women as they search for their wellbeing.

Thus, I am requesting your consent to conduct an interview with you on the same topic. This interview will last for approximately 45 minutes. Please take note that you are free to decide on the time and the venue convenient for you. Participation in this study will not lead to any monetary benefits, nonetheless it will add value to academics and may be used for further research. Therefore, your participation is completely voluntary, and you are free to participate or not to or to withdraw without your participation at any stage without giving any reasons if you so wish. If you are not comfortable with any of the questions asked, you are free not to answer and you will not be compelled to answer it.

I also wish to inform you that all information gathered during this interview will be treated with utmost confidentiality and there will be no identifiers to the information collected. Please take note that no any information will be disclosed to any third party without your written approval and access

to information is restricted to the researcher and will remain anonymity. Thus, details of your identity is not required and transcription of the data will be done in the manner that will not link your responses to your identity. Therefore, pseudonyms will be used in the report or any publication of the findings.

Please take note that the information collected during this interview will be securely stored under a password protected environment and will be stored at the University of Pretoria, Department of Sociology for a minimum of 15 years.

Kindly note that there is no anticipated risk in participating in this study. However, if you feel distressed during or after the interview, let me know so that I can link you up to Chadiza District Hospital, Department of Social Services for counselling services or debriefing.

It is also important that before you agree to participate in this study, you should first understand what is involved. If you are satisfied and agree to participate, please sign the consent form attached. If you have any questions or concerns before or after the interview, you can please, contact me on: Phone number: +260968789220 or by email at: bwalyawils@yahoo.com. You may also contact my supervisor Prof. Catherine Burns on +27829236853 or by email at: cath@burns.org.za.

Consent Form

I hereby consent to participate in the study on "The Search for Healing and Health in Zambian Eastern Province: A sociological investigating of imbricated systems". I understand that my participation in this study is completely voluntary and I wish to acknowledge that I am not forced in any way to participate. I also understand that I can withdraw my participation at any stage of the interview if I want to and my decision will not affect me negatively in any ways.

- I understand that the details of my identity will remain confidential.
- I also understand that this study is being conducted for academic purpose.

…….. …….....

Signature of participants **Date**

Researcher's Signature: ……Date: …….

I am also willing for the interview to be audio recorded.

…….. ……

Signature of participants	Date

Interviewer's signature: …… Date: ……

Appendix C: Non-disclosure Agreement for Research Assistant

Title of the study: The Search for Healing and Health in Zambian Eastern Province: A sociological investigating of imbricated health systems

Name of Research assistant: ----------

[1]. I understand that all the data I will be asked to collect on behalf of the principal researcher is confidential.
[2]. I understand that the contents of the consent forms, interview tapes, audio or interview notes can only be discussed with the principal researcher.
[3]. I will not keep any copies of the information collected nor allow any third parties to access them.

Research Assistant's signature: _____

Research Assistant's name: _____

Date: _____

Signature of Principal Investigator: _____

Name of Principal Investigator: _____

APPENDIX D: Research Ethics Approval Letter

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Humanities 100. 1919 - 2019

Research Ethics Committee

15 July 2019

Dear Mr W Bwalya

Project Title:	The Search for Healing and Health in Zambian Eastern Province: A Sociological Investigation of Imbricated Systems
Researcher:	Mr W Bwalya
Supervisor:	Prof CE Burns
Department:	Sociology
Reference number:	18105093 (HUM049/0519)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 15 July 2019. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr K Booyens; Dr A-M de Beer; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder Andrew; Dr E Johnson; Dr W Kellaher; Mr A Mohamed; Dr C Puttergill; Dr D Reyburn; Dr M Soer; Prof E Taliard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

APPENDIX E: Letter of authority form Chadiza Hospital

RE: CCMO MO 4232 AE: 191449

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
CHADIZA DISTRICT HOSPITAL, EASTERN PROVINCE
Office of the Medical Officer In-charge
P.O. Box 520031, Chadiza, Zambia
Tel: 06 – 251189, Fax 06 – 251179

Dear Mr. W. Bwalya

RE: YOUR REQUEST TO USE OUR COUNSELLING SERVICES DURING YOUR RESEARCH ACTIVITIES

I refer to your letter dated 10th July, 2019 in which you requested for permission to use our psychosocial counseling services or referring your research participants for counseling services if needs arise. I wish to inform you that hospital management has granted you permission to use our psychosocial counselling services without any costs attached. I also wish to inform you that Chadiza District Hospital is a public institution and all services are provided free of charge.

If you need any help, please do not hesitate to contact my office.

Yours sincerely,

Dr. Webby Chisala
Medical Officer In-charge

All Correspondences should be addressed to the Hospital Medical Officer In-charge