



VOLUME 3 ISSUE 3

The International Journal of

Health, Wellness, and Society

Homeopathic Health Care in a Low-income
Housing Estate in Durban
Possibilities for a Plural Health Care Model in South Africa

KIRA ERWIN, MONIQUE MARKS, AND INGRID COUCHMAN

THE INTERNATIONAL JOURNAL OF HEALTH, WELLNESS, AND SOCIETY
www.healthandsociety.com

First published in 2014 in Champaign, Illinois, USA
by Common Ground Publishing LLC
www.commongroundpublishing.com

ISSN: 2156-8960

© 2014 (individual papers), the author(s)
© 2014 (selection and editorial matter) Common Ground

All rights reserved. Apart from fair dealing for the purposes of study, research, criticism or review as permitted under the applicable copyright legislation, no part of this work may be reproduced by any process without written permission from the publisher. For permissions and other inquiries, please contact cg-support@commongroundpublishing.com.

The International Journal of Health, Wellness, and Society is peer-reviewed, supported by rigorous processes of criterion-referenced article ranking and qualitative commentary, ensuring that only intellectual work of the greatest substance and highest significance is published.

Homeopathic Health Care in a Low-income Housing Estate in Durban: Possibilities for a Plural Health Care Model in South Africa

Kira Erwin, University of KwaZulu-Natal, South Africa
Monique Marks, Durban University of Technology, South Africa
Ingrid Couchman, Durban University of Technology, South Africa

Abstract: Homeopathy is often seen in contrast to the dominant model of public allopathic medicine. A case study of a free homeopathic community clinic in a low-income housing estate in Durban, South Africa, suggests that a more productive model for addressing community health and wellness should see homeopathy as part of the solution to affordable public healthcare. Drawing on short structured interviews and clinician data, this paper analyses community responses to the clinic. In the context of South Africa's ailing public health system, a pluralistic approach extends the benefits of choice, accessibility, affordability, and a focus on the individual as user.

Keywords: Community Clinic, Low-income Communities, Plural Health Care Model, Homeopathy, South Africa

Introduction

In February 2011 the Community Development Programme at the University of KwaZulu-Natal (UKZN) embarked on a research and community engagement programme in a place called Kenneth Gardens. Kenneth Gardens is a municipal housing estate located in the working class suburb of Umbilo, within the city of Durban in South Africa. While not comprising of the poorest of the poor it provides subsidised housing to approximately 1500 – 1800 individuals and families who are unable to access market related housing. It is the largest housing estate in Durban. Kenneth Gardens, almost since its inception, has been renowned as a place that is beleaguered with a wide range of social problems, such as alcohol and drug abuse, domestic violence, unemployment, and poor educational achievements. In addition a large portion of the residents have at least one member of the family with a serious physical or mental illness.

Over the years, as will be discussed later, state service provision to this housing estate has declined, leading to a further deterioration of social and health problems. Yet there has been almost no intervention from government or from the non-government sector in trying to alleviate the problems that are so apparent in Kenneth Gardens. In addition, not a single research report or article has been published on Kenneth Gardens. It is for this reason that the UKZN Community Development department elected to partner with a range of other organisations to develop an intervention and research programme with the residents of Kenneth Gardens. The intervention programme was developed with the idea of creating a model for community development and service delivery for low income housing communities in Durban and beyond.

At the outset of this project, a comprehensive survey was conducted in 2011 by the Community Development Programme at UKZN in order to gain some understanding of the demographics of this housing estate and the key concerns of its residents. The survey, which sampled 162 out of 282 household units in the estate, revealed that the most pressing concern of Kenneth Gardens' residents was access to health care. A core aim of the intervention programme, therefore, was to address the health needs of the residents by establishing a primary health care facility (or clinic) within the estate. Initially when a clinic was imagined for Kenneth Gardens the intention was to have a primarily allopathic clinic run by a nurse and doctor, with support from complementary health practitioners. What emerged, through the partnership of UKZN and

Durban University of Technology (DUT), was a homeopathic clinic which has now been running for just over six months.

The homeopathic clinic, run from a small committee room within Kenneth Gardens, operates on a weekly basis from 9am to 12pm, every Wednesday. Interviews, both formal and informal held with clinic users and health care service providers in Kenneth Gardens illustrate that homeopathy, as one form of Complementary Alternative Medicine (CAM), provides users with a positive healthcare experience, despite having never previously been exposed to this form of health care. While the clinic has only been running for a short period of time, what has emerged thus far (in interviews held with clinic users and providers, and clinician records) is that the homeopathic clinic is well supported by Kenneth Gardens' residents and even by residents of the surrounding community. While it is difficult to make any conclusive statements about the effectiveness of the clinic in improving individual health, the clinic is viewed as contributing positively to the general wellbeing of its users.

To our knowledge, this is the first clinic of its kind to be opened in a government run and owned residential space. Homeopathy is new to most residents of Kenneth Gardens who are used to accessing (allopathic) public health care facilities. This paper aims to explore the contribution of this clinic to the health and wellbeing of Kenneth Gardens' residents and to make some commentary on possible models for public health care in low income communities in a country whose public health care is in a fragile and arguably deteriorating state. The reasons for this poor state of public health care are fiscal restraints and the prioritisation of technical rather than developmental considerations (Sanders et al 2006).

What we intend to demonstrate in this paper is that low income communities are responsive to alternative healthcare interventions, even those that are unfamiliar such as homeopathy. We suggest that there are a number of reasons for this. Firstly, residents from low income communities face serious challenges in accessing allopathic healthcare services in South Africa. Besides financial costs Kenneth Gardens' residents for example are zoned for a public hospital which is over 20kms from the housing estate. Secondly, homoeopaths work as holistic healers taking in the patient's mental, general and physical symptoms (Vithoulkas 1998). In a public health setting this could prove to be essential as often the socio-economic factors affecting a patient's health may be ignored or discarded as non-essential, whereas it may play a vital role in the overall well-being of the patient.

This paper does not address the effectiveness of the homeopathic treatment, which we acknowledge is a contentious issue. Rather it focuses on the residents' experiences of the clinic and the effects this may have on overall wellbeing. Neither does this paper argue for complementary and alternative medical services as a substitute for allopathic medical healthcare. Instead, what we propose is that given both the real deficits in public allopathic health care provision in South Africa, and the potential for health and wellbeing improvements through the use of CAM, that models of community healthcare bring together both allopathic and CAM practices. Drawing on the Kenneth Gardens case, we posit that a healthcare model that brings together these two medical approaches allows for choice, accessibility and a focus on the individual as user. While we make no claims about the curative effectiveness of homeopathic treatment, we do argue that alternative medicine does contribute to the overall wellness of users.

Kenneth Gardens in Context

The Kenneth Gardens housing estate was completed in 1948 as part of the then apartheid government's objective of providing subsidised housing to low income 'white' workers. This ambitious project comprises of 28 blocks, 282 units, offering spacious one and a half and two and a half bedroom units, all with Oregon pine flooring. The housing estate, typical of those created for poor 'whites' at the time, has close proximity to public transport routes, schools and other services. Kenneth Gardens was, and indeed remains, a convenient and affordable living

arrangement for many families. True to its name it was also designed with large open grassy spaces as well as many trees and shrubs, all of which blends seamlessly into a small municipal park at its top end. Yet the pretty gardens and the decently designed flats never detracted from a negative public perception of Kenneth Gardens. The estate was associated with working class disruptive and abhorrent behaviour, such as alcohol abuse and unsupervised gangs of youth. While these perceptions were often class framed stereotypes they did resonate with some residents' everyday realities.

Kenneth Gardens as a space of 'white' protectionism began to change from the late 1980s, as the Group Areas Act¹ began to lose its hold and was eventually repealed in 1991. By 1988 the state had drastically reduced its budget spent on 'white' housing (Parnell 1992, 56) and in 1989, the first 'black' family moved into Kenneth Gardens. Today Kenneth Gardens accommodates a diverse resident population, with 'white' residents now in the minority. This diversity does not live only in the changing racial profile, but in family environments, people's links to other communities, religious affiliations, health needs and economic earnings to name a few. Although the majority of residents, by virtue of their income, still fall into the earning threshold required to remain in the estate, different life circumstances, structural barriers, and opportunities shape these intimate spaces in vastly different ways.

Many of the social issues such as alcoholism, unemployment and domestic violence remain part of the story of Kenneth Gardens 18 years after the move to a democratic South Africa. But what is markedly different is the drastic petering out of social and health services to the estate, since the early 1990s. State social workers, previously frequent visitors to the estate, have for the most part been withdrawn from the everyday lives of residents. Many blocks of flats require urgent maintenance, both structurally and in terms of aesthetics, and the grass and gardens are no longer the well-kept shrubberies of the past. The inadequate maintenance of the flats and gardens is possibly due to a lack of municipal budget, which has a small contract work force for this large ground. There is no longer an allocated ground keeper in Kenneth Gardens. This is in sharp contrast to apartheid times when 15 labourers were allocated to Kenneth Gardens to maintain the grounds and gardens (3DBN/1960s/Housing File General).

Our aim here is not to romanticise the past. It is worth remembering that under apartheid racial oppression provided a subsidised and exploited labour force for the municipality. Likewise the strong interventionist approach in poor 'white' areas, before and during apartheid, was part of a larger protectionist project for 'whites' by the then South African government. During the 1930s and 1940s this protectionism took on a particular spatial design of building housing estate, or suburbs, which afforded 'white' families cheap rents and protected spaces in which to uplift their socio-economic livelihoods (Teppo 2004, 14). This welfare was wrapped up in ideas of race, nation and class. Poor 'whites' posed a threat to the idea of white supremacy and represented a 'racial weakness' in the constructed racial hierarchy of the South African government (Teppo 2004, 61). The social order of capitalism was also threatened by poor 'whites', since their insecure economic position carried possibilities of creating a unified working class that cut across racial boundaries (Parnell 1993). As a result, subsidised housing and the myriad of social services and interventions provided was aimed at rehabilitating 'white' citizens to their 'rightful' place in the social order of South African society. Access to good medical care was also provided. Public hospitals offered world class medical care to protected 'whites'. Kenneth Gardens' residents were able to access health care services at King Edward Hospital, less than two kilometres away from the estate.

As these types of protectionist programmes fell away, people living in places such as Kenneth Gardens were increasingly left to fend for themselves. As low cost housing, previously not available to 'black' South Africans, were opened up the safety nets available to deal with social, medical and welfare problems were essentially reigned in. Kenneth Gardens' residents no

¹ The Group Areas Act (Act No. 41) passed in 1950, consolidated existing discrimination and segregation in South Africa through legalizing, and enforcing, separate residential spaces and facilities based on racial classification.

longer have access to King Edward Hospital, instead, they are expected to travel more than 20km to Wentworth Hospital for medical care. The majority of residents do not have access to private transport and the two taxis required to get to Wentworth Hospital is costly. Those who are ill or disabled find the travel to Wentworth Hospital almost impossible. And while the services at Wentworth Hospital are comparable to other public hospitals in South Africa, Kenneth Gardens' residents complain they find the service that they receive here to be impersonal, fragmented and clinical.

Two non-state initiatives in Kenneth Gardens attempt to address this lack of accessible health care. The first is a Non-Profit Organisation called Senzokuhle Home Based Care. Started in 2009 by a group of women residing in Kenneth Gardens it offers informal home based care for residents in need, this includes cooking food, cleaning units, accompanying residents on hospital visits, dressing wounds and therapeutic massage. The women of Senzokuhle operate on a completely volunteer basis. The second is the homeopathic clinic run by the Durban University of Technology (DUT) Homeopathy Department, in partnership with the UKZN Community Development Department. This clinic is based on an existing homeopathy clinic model run by DUT in Warwick Triangle (the central transport and market hub in the city of Durban), which offers access to fourth and fifth year homeopathic students who are supervised by a qualified homeopath (Ngobese et al 2010). Funded by DUT the Kenneth Gardens' clinic services and treatment are free of charge for users. What makes the Kenneth Gardens clinic unique is the relationship between these two non-state organisations. Whilst DUT student and staff provide homeopathic consultations and treatment, the women of Senzokuhle take care of patient administration and assist patients with filling out forms, translations from isiZulu to English during consultations, as well as basic wound dressing from members who have nursing assistant qualifications. Senzokuhle members are also able to provide additional affirmation that the homeopathic powders used for treatment are worth trying to patients who are used to allopathic and in some cases traditional (indigenous) treatment. In addition the Senzokuhle members are able to identify residents in need who are unable to physically attend the clinic, and accompany the homeopathic doctors on home visits to these residents. The coming together of these two organisations provides a health care intervention that while on the one hand may be unfamiliar in its philosophy and treatment, is also importantly introduced through familiar community members already involved in caring for the community's wellbeing.

Prior to discussing the data and findings from this case study we would like to introduce some of the key debates and developments in the role of homeopathy in a pluralised governance of health. As we try to demonstrate in the next section homeopathy has been marginalised, along with other CAM practices, but is beginning to gain recognition as an important contributor to low income communities. While still not part of the formal public healthcare sector in most countries CAM practitioners are beginning to establish outreach practices in low income communities, and international organisation like the World Health Organisation are promoting a plural approach to public health care provision. The reasons, for users, to make use of these services are multiple and are discussed below.

Homeopathy and Plural Health Care Provision in Low-income Communities

In places like the United States, alternative medicine is used generally by people who are 'educated, middle class white persons between the ages of 25 and 49 years' (Astin 1998, 1549). Part of the reason for this is that homeopathy is not yet integrated into public health services. The spread and imposition (through colonisation) of Western medical philosophy and practice throughout the world led to the global mainstreaming of allopathic medicine in the public health system (Prasad 2007). Alternative health care systems have been marginalised, and are located in non-state (often private) spaces. Even in India with its long and 'tested' tradition of indigenous

medicines (ayurvedic, unani and homeopathy), 'qualified allopathic doctors...occupy the dominant position in the plural medical system' (Prasad 2007, 3496).

Yet despite the formal dominance of allopathic medicine in the public health system, in most developing countries alternative medical services are used widely. In Cameroon, for example, about 80 percent of people rely on traditional health care practices, such as indigenous phytotherapies (the practice of using herbal medicine), for primary health care needs. This, Timah (2000) believes, is because indigenous medical systems have cultural relevance and are accessible. In addition, the public health system in Cameroon is in a state of decay, and people, particularly the poor seek health care services that are accessible and inexpensive. Similar observations have been made in other parts of the world leading the World Health Organisation (WHO) to promote the integrated use of alternative medicine. According to Taylor (1996), the WHO estimates that up to 80% of the world's population still uses herbs as their primary source of medicine. Since 1978, the WHO has made the case clearly that no one medical system has all the answers to all health problems and that the best possible health care model is a plural one (Romero-Daza 2002; Timah 2000). Such a model, the WHO argues, should be 'ecologically, economically and culturally sustainable' (Timah 2000, 364).

It is not just international regulatory organisations such as the WHO that recognise the importance of a plural approach to health care and wellbeing. National governments (including in developed countries) are also beginning to recognise that that alternative medicines, such as homeopathy, are growing in popularity because they are viewed as more natural, less costly, and holistic. Despite this acknowledgment, for the most part, alternative medicine is not yet part of national public health care services (Jonas 2002). This might change as there is growing pressure (in places like the United States) from medical associations and academic departments for governments to integrate biomedicine and alternative (complementary) medicines within the public health care system (Jonas 2002).

In Africa, Ghana stands out as the only country where several decrees have been passed to regulate and ensure the integration and integrity of traditional medical practices, including homeopathy. Most governments, in Africa and beyond, have been very slow in taking up recommendations in regard to the recognition and integration of alternative medicine. This is because, governments argue, there is a lack of 'scientific evidence' as to the efficacy of alternative medicine, and there are difficulties in regulating alternative medical practice (Timah 2000).

The biomedical model thus remains dominant in public health systems across the world. In large part this is due to colonial impositions in all areas of governance, including the governance of health. Its dominance is also due to the many scientific and technological advances that have been made in modern allopathic medicine. Modern medicine has dramatically decreased mortality rates and has made huge strides in terms of surgery and the use of very advanced equipment such as MRIs. Yet while biomedicine has had many advances, these have come with costs, both financial and interpersonal. Biomedical practice is experienced, particularly by the 'poor-sick', as impersonal. Disease is viewed as simply biological, and little account is taken of the social and psychological contributors to ill health by allopathic medical practitioners (Clark 2000; Jonas 2002). Technological medical interventions increase feelings of depersonalisation, and they are expensive. Drug costs are also mounting, especially for chronic illness. As Jonas puts it, biomedicine 'has mastered the cure, but it struggles with the care and costs too much' (2002, 31).

Complementary and alternative medicine (CAM) has stepped in where biomedicine has faltered. Patients who opt for CAM, according to Jonas, 'generally find visits to CAM practitioners more satisfying than visits to conventional practitioners who only offer biomedicines' (2002, 32). Homeopathic practitioners, for example, seek to cure their patients on physical, mental and emotional levels. Treatment is tailored to individual need. Furthermore, alternative medicines, such as homeopathic pills and powders, make use of herbs and plants to

promote wellbeing. The use of these natural substances is not only viewed as less harmful to the human body and to the environment, it also resonates with traditional, embedded forms of healing (Clark 2000). This has led Astin (1998) to conclude that it is not surprising that homeopathy resonates with people who are familiar with traditional forms of healing. In this view, homeopathy, while not formally integrated into the public health care system, may be more congruent with many people's everyday beliefs and practices regarding health care and wellbeing than is the case with conventional modern medicine.

Neoliberal economic policies have led to a general decline in the accessibility of poor people to public health care facilities. This has led to an on-going cycle of poverty and poor health given that poverty is one of the greatest determinants of ill health. Poorer people have less access to good nutrition and to health facilities. In addition, 'poverty influences health status through a variety of mechanisms, including material deprivation, excessive stress, uncertainty, and unhealthy behaviours' (Stewart et al 2005, 107). Yet despite this widely accepted knowledge there has been a global resistance to looking beyond Western modern medicine in government circles; most government funded research on health care aimed at the poor focuses on publicly funded 'formal' health care, and more narrowly on allopathic medical care (Stewart et al 2005).

The result of all of this is that while low income people tend to use public health facilities more frequently than others in treating illness, they under-use preventative services and health services that are not publicly funded. This includes alternative health care such as homeopathy. CAM practitioners have recognised the lack of fit between experiences of wellbeing and the use of public health facilities in preventing illness. In recent decades there have been attempts by homeopaths to embed CAM in poorer communities, to provide a holistic service which is affordable. Homeopathic clinics have now been established for the poor-sick in places as far apart as the Bay Area in San Francisco, to India, Kenya and Botswana.

In Botswana, The Maun Homeopathy Project was established in October 2005 for HIV and AIDS sufferers. This project works in partnership with local community organisations and agencies. A mobile clinic is provided to those most in need. This mobile clinic offers home visits as well as a point for community members to come and receive treatment. The clinic serves over 1500 people (The Maun Homeopathy Project Newsletter 2007). In August 2007, Edward Cameron, Justice of the Supreme Court of Appeal in South Africa and internationally recognised HIV and AIDS activist, visited the Maun Homeopathic Project. According to Justice Cameron, the clinic is having an undeniable beneficial impact. Users, mostly struggling with HIV and AIDS, have reported universally that the clinic has been incredibly successful in regard to its interventions and treatments, particularly in dealing with the serious negative side effects of ARVs and in restoring immune systems. In a report published after his visit he writes of the clinic:

I left elated because of the depth of the work that the MHP is doing, the patient benefits the patients report, and because a colossal global experiment in social justice – bringing life to those who otherwise face certain death from AIDS – is being professionally, expertly and lovingly boosted.

In his review on the clinic, Cameron states that he too makes use of homeopathic treatment. He started using ARV treatment in 1997 and in 1980 began to regularly visit a homeopath in Cape Town who has managed to clear persistent mouth and gum infections which antibiotics were not effective in healing. Justice Cameron is a patron of the Maun Homeopathy Clinic (The Maun Homeopathy Project Newsletter 2007).

In Malawi the Chintech Homeopathic Clinic treats a wide variety of ailments and illnesses. The clinic founders have also established a programme that trains community care providers. These community care providers treat community members who are struggling with HIV and AIDS, malaria and Tuberculosis. This clinic is funded by the Amma Resonance Healing Foundation (ARHF), and is well used by those who find it difficult to access medical care at the

local hospital. According to the ARHF, the local hospital is geographically inaccessible and lacks basic resources and medicines as a result of fiscal challenges confronted by the Malawian government (Amma Resonance Healing Foundation Newsletter 2012).

The choices that low income communities make in regard to seeking health care is, according to Stewart et al (2005), determined by proximity, affordability, convenience, information and providers attitude and behaviour. Research conducted in low income communities in Canada indicate that users were mostly concerned about medical practitioners' behavior and attitude in deciding what health care services to access. Homeopathy is rapidly becoming more popular because users want to be treated 'with respect, compassion and care, and they [want] service providers to spend time with them' (Stewart et al 2005, 115). Stewart et al (2005) contend that people living in poverty want health care providers who are able to listen, understand and empathise with them. Accessibility and affordability were also viewed as important variables. Low income users simply will not use services that are not affordable to visit or get to (Stewart et al 2005). For health care services to be used, and therefore to assist in breaking the cycle of poverty and illness, accessibility is important.

Similar studies have been conducted in the United States amongst low income African American asthma sufferers. George et al (2006) found that within this community there was a general preference for natural choices in dealing with chronic illness. People interviewed stated that they were 'tired of all the medicine they took' which was provided by the allopathic public health care facilities (George et al 2006). They indicated a preference for alternative health care services (such as homeopathy) which were viewed as safe, effective and potentially curative. Interviewees recognised the need for allopathic medicine but stated a clear preference for combining alternative and conventional medicine in dealing with their health problems (in this case asthma).

It would seem that for the sick people from low income communities, the debates about choices in the healthcare sector between allopathic or alternative, modern or traditional, 'does not provide any great clarity in terms of treatment seeking patterns' (Prasad 2007, 3496). Medical care cannot be understood in purely objective or 'scientific' terms. Social values, proximity, cultural resonance, and affordability must all be incorporated into assessments of what medical practice and service works best, and in our attempts to create smart public health models. With this in mind, we present preliminary findings about the use of homeopathic services by Kenneth Gardens' residents, most of whom had no familiarity with homeopathy prior to the establishment of the homeopathic clinic within the estate.

The Kenneth Gardens Homeopathy Clinic

When King Edward VIII Hospital located on Umbilo Road, and within easy walking distance from Kenneth Gardens, changed from a district to a regional and tertiary hospital, residents of Kenneth Gardens lost official access to this resource. Residents were then rezoned to use Wentworth hospital, a district hospital, in the Bluff, over 20 kms away from the estate. Whilst some residents have managed to retain access to King Edward through informal and individual negotiations, most residents are required to catch public transport, first into the centre of town and then out to the Bluff. In addition the ward in which Kenneth Gardens is located no longer has a state funded municipal clinic. Within this restrictive context the homeopathy clinic located within the estate itself has, unsurprisingly, been well-received by the community.

As of the 15th August 2012 the clinic has seen 153 users of variant ages, although most of whom are over the age of 50 (see *Table 1*) and predominantly women. These demographics reflect the opening time of the clinic, which operates during working hours on a Wednesday morning. Whilst clinician data indicates that most users have attended the clinic once or twice and two users as many as 16 times, the accuracy of the frequency statistics is unclear since according to the clinic's coordinator users often return to the clinic for additional medication

without a consultation, which is not recorded in the users’ records. User conditions are variance with three noticeable groupings that correlate to other low-income community research on health; respiratory conditions, diabetes and hypertension (see *Table 2*). The first of these respiratory conditions may well be influenced by the season, as this study takes place over the winter months in Durban; however low-income communities globally are known to show high incidence of these conditions, including asthma (Masoli et al 2004). In the South African case this may also reflect symptoms related to tuberculosis. Diabetes and hypertension are common (non-communicable) conditions within low-income communities (Bodenheimer et al 2002; Alwan et al 2010; Ward et al 2000; Bindman 1995).

Table 1: Age Groups of Kenneth Gardens’ Homeopathic Clinic Users

<i>Age Group</i>	<i>Number in Age Group</i>
0-9 years	16
10-19 years	6
20-29 years	16
30-39 years	11
40-49 years	19
50-59 years	44
60-69 years	24
70-79 years	12
80-89 years	4
90-99 years	1

Source: Clinician Data from the Kenneth Gardens Homeopathic Clinic.

Table 2: Frequency of Medical Conditions of Kenneth Gardens’ Homeopathic Clinic Users

<i>Condition</i>	<i>Frequency</i>
Dermatological	9
Arthritis	42
Hypertension	39
Diabetes mellitus	25
Otic conditions	12
Cardiovascular conditions (excluding hypertension)	10
Cancer	3
Vascular conditions	3
Respiratory conditions (including influenza, sinusitis, asthma etc.)	50
Neurological conditions (including epilepsy, headaches, insomnia, neuropathy, etc.)	25
Gastro-intestinal conditions (including ulcers, constipation, etc.)	33
Nephro-urological conditions	11
Female reproductive system (including menstrual conditions, menopause, leukorrhea, etc.)	8
Infections (including HIV, bacterial and viral infections)	13
Ophthalmological conditions (including conjunctivitis, cataracts, visual disturbances, etc.)	12
Endocrine conditions (excluding diabetes mellitus)	2
Anaemia	3
Musculoskeletal conditions (excluding arthritis)	17
Injuries	3

Source: Clinician Data from the Kenneth Gardens Homeopathic Clinic.

The homeopathy students and qualified homeopaths working in Kenneth Gardens not only provide homeopathic treatment for the above tabulated conditions but also offer other basic health services. In order to practice homeopathy in South Africa, a practitioner needs to be registered with the Allied Health Council. The normal registration is through a Master's degree in Technology: Homeopathy encompasses medical subjects, including Anatomy, Physiology, Diagnostics and Pharmacology. The practitioner is also educated in homeopathic medication and consultation (Homeopathic Association of South Africa 2011). This training is useful in providing services such as blood pressure and blood sugar monitoring, both of which are offered at the Kenneth Gardens' clinic. Given the high incidence of diabetes and hypertension in the estate this service alone is valuable for residents to monitor and manage their chronic conditions.

When users visit the homeopathic clinic at Kenneth Gardens they receive an extensive consultation with one of the clinic staff about the history and current state of their health and wellbeing, as well as their family and social circumstances. Users then discuss with clinic staff the condition they are presenting with, the clinic co-ordinator in consultation with the clinic staff member dealing with the individual patient does an overview of the case and determines an appropriate homeopathic treatment. The treatment given at the clinic includes homeopathic pills and powders but does not include herbal medication often used by homeopathic practitioners. Herbal pills are currently not being used because according to the clinic coordinator they are very expensive and cannot be given out freely whereas homeopathic pills and powders are inexpensive. Sponsorship is being sort for the provision of herbal pills.

In August 2012, four months after the clinic first opened, short exit interviews were held with clinic users. These 30 interviews were conducted by the 3rd year Community Development students and academic staff. Clinic users were approached after they had finished their consultation and treatment, and asked whether they were willing to do a short interview on their experiences of the clinic. The large majority of users agreed to this. The interview schedule, comprising mostly open ended questions, focused on the following: health reason for visiting the clinic; the accessibility of the clinic services; experiences of the services and treatments at the clinic; the impact of the clinic service on general wellbeing; possible improvements for the clinic; use of other forms of medicine outside the clinic; and user perceptions of homeopathic treatment.

There are a number of themes that come out of these interviews. Firstly, all users stated clearly that the clinic is beneficial; the predominant reason for this is the proximity of the clinic given that it is based within the housing estate itself. The fact that users do not have to travel to a health facility also reduces healthcare costs, and users are greatly appreciative of this since they lack the financial resources to travel to public facilities that have been made available to them such as Wentworth hospital. As one user put it the 'clinic helps a lot, I'm feeling better after a week. The clinic helps because there are no transport costs and it is free of charge and there are lots of unemployed people here' (Interview, 4 July 2012).

Users were also in agreement that the clinic providers were friendly, concerned and spent time trying to understand their individual health needs and histories. In addition users were impressed at the efficiency of the clinic since they did not have to wait long to see a provider. They compared this with the service they received at the public hospitals which they describe as time wasting, expensive (transport costs), overcrowded and being thought of as 'just a number'. Given that the clinic has only been operational for four months it is difficult to draw any hard and fast conclusion about the efficacy of the medication – and it is not the intention of this paper to do so. Yet what is clear to us is that the clinic is full every week and almost all users interviewed requested that the clinic hours be extended and that other healthcare professionals join forces with the homeopathic team. There were a number of users who stated clearly that they are convinced that homeopathy is a worthwhile and even a preferable alternative to allopathic public treatment. While initially users were still unsure about the effectiveness of the medication given at the homeopathic clinic within weeks of the clinic opening there was much talk in Kenneth

Gardens about the “magic powders” that people were receiving from the clinic. This is interesting because it seems as though there is some resonance with more traditional forms of therapies, which many Kenneth Gardens’ residents may be familiar with particularly in the areas they lived in prior to Kenneth Gardens.

To further illustrate some of the findings above we are now going to briefly discuss the cases of two of the regular clinic users. The first of which is Jack, a 58 year old resident of Kenneth Gardens. He is unemployed, has three adult sons and is active in a wide range of community based activities in Kenneth Gardens. In mid-2011, Jack was diagnosed with a brain tumour after being referred to King Edward Hospital. Jack is one of the few residents of Kenneth Gardens who has managed to negotiate access to this facility. When he was diagnosed with the tumour he became very depressed and a number of associated health problems began to emerge, including hypertension. Towards the end of 2011 Jack was referred to the oncology department at a specialist hospital, Albert Luthuli, to surgically remove the tumour. The surgery was successful but following the operation Jack became anxious and his hypertension worsened. Regular visits to the hospital indicated that his high blood pressure was spiking despite being on the prescribed allopathic medication. From the day the clinic opened in Kenneth Gardens Jack has been a weekly user of its services. According to the homeopathic clinic records as well as an interview with Jack, his blood pressure has consistently decreased since attending the clinic and taking the homeopathic treatment. In Jack own words,

This homeopathic stuff is helping me so much. It is bringing my blood pressure right down. It is much better than the medicine that I am getting at the hospital. I am so amazed by how this stuff works. I think the clinic should be opened more often, let’s say twice a week. My experience with the clinic is much better than the hospital. I have had no positive results from the hospital. The homeopathic staff is very friendly. They know my name and they treat me as an individual. At the government hospitals you don’t get this kind of treatment. People at Kenneth gardens are more at home with the treatment here than at the hospital. At the hospital you are just treated as a number. At the hospital they don’t engage with you at all. They just want to process all the patients. I fully believe in this kind of treatment. It is proven by my clinic sheet. You can see my progress. At the provincial hospital this was not happening. I feel more at home here. The way they talk to you, you feel listened to. Here they know me and they know exactly what to give me. They greet me in a friendly way. (Jack, Interview, 22 August 2012)

Jack is convinced that homeopathy has assisted him with his chronic hypertension problem far better than the treatment he received at the public hospital. Interestingly the clinic coordinator indicated that she felt Jack’s blood pressure results in the clinic were probably due to the fact he experiences ‘white coat syndrome’ at the hospitals. According to Calhoun et al white coat syndrome is ‘when clinic blood pressures are persistently elevated while out of office values are normal or significantly lower’ (2008, 1406). How can we interpret this case? Jack believes that homeopathy is working, and perhaps it is. However of equal significance is that the homeopathic environment seems to have dramatically assisted with the regulation of his blood pressure since he does not experience anxiety during his consultations at the Kenneth Gardens’ clinic. Jack’s experience of the public health service is hardly surprising given the increase in disease burden in recent decades coupled with the increase in public sector patient load, low hospital staff morale and a poor human resource strategy plan (Botha and Hendricks 2008, 28).

Nomondi is another regular user of the homeopathic clinic at Kenneth Gardens. She is 50 years old and been living in Kenneth Gardens since 1998. She struggles with rheumatoid arthritis and presented at the clinic with this condition as well as an open undressed wound on her leg resulting from a procedure at the hospital. She began attending the clinic because she was dissatisfied with the treatment received at the public hospital, although she recognises the need to

continue with allopathic medication for her chronic condition. In an interview with her what emerged is that she feels personally empowered by the type of service provided by the clinic, and like Jack is a “homeopathic convert”. As she puts it,

The clinic has helped me a lot. There is a powder which they gave me which makes me stronger. I now do things that I was afraid to do before, like walking far. Before the clinic I felt sick all the time. I have rheumatoid arthritis. The powders have helped me a lot. I still go to King Edward Hospital, and am using treatment from Albert Luthuli Hospital. In King Edward they don't treat you properly. They always tell me they don't have the right medicine. I go to Albert Luthuli mostly for a wound which I have had. They are also treating me for the arthritis. I use the hospital and the clinic. The clinic powder is working and they check my condition. They have also written letters for me to take to the hospital to deal with the wound. My friends in Kenneth Gardens are very happy about the clinic. We want more days and hours so we can bring our children. We hope that the clinic at Kenneth Gardens gets stronger and gets more equipment so they can help with wounds and things like that. (Nomondi, Interview 22 August 2012)

Nomondi's new found sense of physical capability is a result of being treated individually and with care and concern by the homeopathic staff. Her open wound for example was cleaned by a member of Senzokuhle and clinic staff monitors her wound in weekly visits. It is worth noting however that the homeopathic clinic as it currently stands is not equipped with materials such as bandages and ointments to optimally treat problems such as this. Nonetheless at the most recent clinic visit on the 22nd August 2012 the wound is now almost healed and Nomondi attributes this to the care of the homeopathic clinic. What is useful to note about Nomondi's case is that for her being able to choice among and use various healthcare services, both allopathic and CAM, is empowering and medically beneficial.

What has emerged in the short life span of the clinic in Kenneth Gardens is that there is a high level of responsiveness from a low-income community. As we have already indicated part of this is due to the nature of homeopathic care, however it is also a result of high levels of dissatisfaction with an ailing public health care system. This is not unique to South Africa and similar findings are published from other countries, including established liberal democracies. For example, a study conducted on public health care facilities amongst low-income Hispanic adults in California reveal patient dissatisfaction with hospital care for chronic illness, and linked to this non-compliance with treatment. According to Ward et al evaluations of public health care facilities (all of which being allopathic) ‘suggested that several aspects of care were undesirable, including block scheduled appointments and accompanying long waiting times and a lack of continuous care from designated physicians. Furthermore, limited opportunities were afforded patients to communicate with staff concerning their health and treatment’ (2000, 178).

The research is exploratory, but it did yield important data about homeopathy and the pluralisation of health services in low income communities. Further investigation is required within Kenneth Gardens after a longer clinic user period to ‘test out’ whether the meanings and perceptions in regard to the clinic endure or change.

What is clear from the preliminary research, however, is that a service like the Kenneth Gardens clinic is beneficial in low-income communities. However, for a clinic such as this one to provide optimal health care services a more comprehensive and networked approach is required. A plural model needs to be implemented which allows users to be able to access health care practitioners from both the CAM sector and from the allopathic sector. Ideally, a registered nurse should be available at all times during the running hours of the clinic to provide amongst other services, immunization, administer medications from the public hospitals, and dress wounds. A network needs to be established which allows for referrals between various health care providers and facilities. Clinics such as the one at Kenneth Gardens need to be given recognition and support by government and the private sector in order to ensure that initiatives such as this are

adequately equipped to deal with primary health care problems, monitor chronic illness, and be given adequate space to allow for private consultations within the clinic setting. In addition localised clinics that operate on a plural model should be open as frequently as required, taking into account the particular demographics and needs of its users. At present, the Kenneth Gardens Clinic, while without doubt an asset to the Kenneth Gardens community, is limited because it lacks the above requirements. This was pointed out by clinic users and by staff.

Reflections and Suggestions

In August 2012, the South African National Planning Commission, based in the Office of the President, released its National Development Plan 2030 (2012). The National Development Plan (NDP) is aimed at eliminating poverty and inequality in South Africa by 2030. It aims to do this by engaging all sectors of the South African society through building state capacity. The NDP is based on diagnostic analysis of most aspects of South African life and on extensive consultation with experts and stakeholder groupings. Promoting health is one of the key components of the NDP.

The NDP document acknowledges the poor state of the health system in South Africa at present. According to this document, services are fragmented, management is top-down, staff morale is low, there is poor authority, as well as poor accountability and adherence to policy. Key to addressing these failures is creating a primary health care system which is accessible, patient focused (as opposed to disease focused) and comprehensive. The plan also calls for health care services which are timely, local, and, as far as possible, home based (NDP 2012, 331). This resonates with the primary objectives of the Department of Health (2012) which includes changing 'health service delivery from a curative model to one that promotes cost-effective primary healthcare as close to the community and households as possible'.

The NDP document places great emphasis on the need to integrate community health care workers into the wider health care system. Drawing on 'successful' case studies from Thailand, Rwanda, Iran and Brazil, it is argued that increased use of community health care workers is extremely beneficial. It allows for cost effective health care provision, improved access to services through localisation, and active citizen involvement in health care. It is of interest to note that nowhere in the NDP document is there any mention of integrating biomedical and CAM services in the creation of an accessible, patient centred, cost effective, holistic and preventative health care system. No mention is made of the need for a pluralised approach to the provision of health care, particularly to low income communities.

There is much to be learned, we believe, from the local case of the homeopathic clinic within the Kenneth Gardens housing estate. First and foremost, to achieve the goals of the Department of Health and the National Development Plan, it is crucial to develop models of health service provision which are plural. This means that serious consideration needs to be given to the integration of CAM practitioners and services within the public health care service. Such integration contributes to user choice, patient centred treatment, and cost effective services. The users of the Kenneth Gardens clinic did not see the clinic as antithesis to the public health sector and were comfortable utilising services across these two settings depending on their specific health needs. Remodeling community health care along these (pluralised) lines makes sense in terms of the feedback from users, economically, and in terms of government policy.

Low income communities value health care services that are accessible, cost effective, patient focused, and that effectively treats illness (broadly defined). What is also apparent from the Kenneth Gardens study is that local health care facilities work best when community health care workers, like the women of Senzokhule, are actively involved. They bring with them knowledge of localised health care needs of the community and an understanding of the context of individual users. Often, as is the case in Kenneth Gardens, community health care workers have personal ties with individual users and this promotes trust in using health care facilities

which is crucial in terms of compliance with treatment as well as in regard to placing trust in the health care providers themselves.

Our goal here is not to argue that homeopathy is a medical service of choice amongst low income communities. What we have tried to demonstrate is simply that homeopathy, like other CAM services, has a proper place in primary health care models. The services they provide are holistic, natural, affordable, and individualised. All of these attributes were recognised and appreciated by Kenneth Gardens' residents who made use of the homeopathic clinic. In a plural health care facility there could be a robust exchange of knowledge and practice between allopathic and CAM health care providers. A networked approach to health care for low income communities is, we believe, the only way the goals in the NDP can be attained. In an era where there has been a notable decline in government capacity to govern public health and welfare needs, the most viable solution is to draw on all available medical knowledge, capacity and skills regardless of whether these are state or non-state, allopathic or alternative. We would like to suggest that pluralised models for public health care provision in low income communities be piloted in other parts of South Africa, and that a comprehensive assessment of these services be conducted, preferably by a combined team of government and non-government researchers.

Acknowledgement

The authors would like to thank the clinic users from Kenneth Gardens for so willingly participating in the study. Research funding for this project has been provided by the National Research Foundation (NRF) as part of a community engagement research grant.

REFERENCES

- Alwan Ala, MacLean David R, Riley Leanne M, d'Espaignet Edouard T, Mathers Colin D, Stevens Gretchen A, Bettcher Douglas. 2010. "Monitoring and Surveillance of Chronic Non-Communicable Diseases: Progress and Capacity in High-Burden Countries." *Lancet* 376: 1861–68.
- Amma Resonance Healing Foundation Newsletter. 2012. Accessed from: http://www.arhf.nl/docs/ARHF_Newsletter_April_2012.pdf.
- Astin John A. 1998. "Why Patients Use Alternative Medicines: Results of a National Study." *JAMA* 279(19): 1548–1553.
- Bindman Andrew B, Grumbach Kevin, Osmond Dennis, Komaromy Miriam, Vranizan Karen, Lurie Nicole, Billings John, Stewart Anita. 1995. "Preventable Hospitalizations and Access To Health Care." *JAMA* 274(4): 305–311.
- Bodenheimer Thomas, Wagner Edward H, Grumbach Kevin. 2002. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2." *JAMA*, 288(15): 1909–1914.
- Botha Claire, Hendricks Michael. 2008. *Financing South Africa's National Health System through National Health Insurance: Possibilities and Challenges*. Cape Town: HSRC Press.
- Calhoun David A, Jones Daniel, Textor Stephen, Goff David C, Murphy Timothy P, Toto Robert D, White Anthony, Cushman William C, White William, Sica Domenic, Ferdinand Keith, Giles Thomas D, Falkner Bonita and Carey Robert M. 2008. "Resistant Hypertension: Diagnosis, Evaluation, and Treatment: A Scientific Statement from the American Heart Association Professional Education Committee of the Council for High Blood Pressure Research." *Hypertension* 51: 1403–1419.
- Clark Peter A. 2000. "The Ethics of Alternative Medicine Therapies." *Journal of Public Health Policy* 21(4): 447–470.
- George Maureen, Birck Kathleen, Hufford David, Jemmot Loretta S, Weaver Terri E. 2006. "Beliefs about Asthma and Complementary and Alternative Medicine in Low-income Inner-city African-American Adults." *Journal of General Internal Medicine* 21(12): 1317–1324.
- Homoeopathic Association of South Africa. 2011. Accessed from: http://www.hsa.org.za/index.php?option=com_content&task=view&idItemid=86.
- Jonas Wayne B. 2002. "Policy, the Public, and Priorities in Alternative Medicine Research." *Annals of the American Academy of Political and Social Science* 583: 29–43.
- Masoli Matthew, Fabian Denise, Holt Shaun, Beasley Richard. 2004. "The Global Burden of Asthma: Executive Summary of the GINA Dissemination Committee Report." *Allergy* 59(5): 469–478.
- National Planning Commission: *National Development Plan 2030*. 2012. Accessed from: <http://www.npconline.co.za/medialib/downloads/home/NPC%20National%20Development%20Plan%20Vision%202030%20-lo-res.pdf>.
- Ngobese Jabulile, Smillie Tracey, Naude David. 2010. "Healing Warwick Junction through Homeopathy: A Holistic Approach". In F. Khan, N. Ramlutchman (eds.). *(Re)searching Durban*. Durban: Breeze Publishing.
- Parnell Sue. 1993. "Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation." *Journal of Southern African Studies* 19(3): 471–488.
- Parnell Sue. 1992. "State Intervention in Housing Provision in the 1980s." In D.M. Smith (ed.). *The Apartheid City and Beyond: Urbanization and Social Change in South Africa*. London: Routledge.

- Prasad Purendra N. 2007. "Medicine, Power and Social Legitimacy: A Socio-historical Appraisal of Health Systems in Contemporary India." *Economic and Political Weekly* 42(34): 3491–3498.
- Romero-Daza Nancy. 2002. "Traditional Medicine in Africa." *Annals of the American Academy of Political and Social Science* 583: 173–176.
- Sanders David, Chopra, Mickey. 2006. "Key Challenges to Achieving Health for all in an Inequitable Society: The Case of South Africa." *American Journal of Public Health* 96(4): 73–79.
- Stewart Miriam, Reutter Linda, Makwarimba Edward, Rootman Irving, Williamson Deanna, Raine Kim, Wilson Doug, Fast Janet, Love Rhonda, McFall Sharon, Shorten Deana, Letourneau Nicole, Hayward Karen, Masuda Jeff, and Rutakumwa William. 2005. "Determinants of Health-service Use by Low Income People." *Canadian Journal of Nursing Research* 37(3): 104–131.
- Taylor David. 1996. "Herbal Medicine at a Crossroads." *Environmental and Health Perspectives* 104(9): 924–928.
- Teppo Annika. 2004. *The Making of a Good White: A Historical Ethnography of the Rehabilitation of Poor Whites in a Suburb of Cape Town*. Helsinki: Helsinki University Press.
- The Maun Homeopathy Project Newsletter. 2007. Accessed from: <http://www.homeopathy-school.com/downloads/misc/Botswana%20NL%20Feb07.pdf>.
- Health, Department of. 2012. *National Health Insurance*. Pretoria: Department of Health. Accessed from: <http://www.doh.gov.za/list.php?type=National%20Health%20Insurance>.
- Timah Nga J. 2000. "Herbal Medicine in Cameroon and North Carolina." *Appalachian Journal* 27(4): 354–367.
- Ward Harry J, Morisky Donald E, Lees NB, Fong Ronald. 2000. "A Clinic and Community-based Approach to Hypertension Control for an Underserved Minority Population: Design and Methods." *American Journal of Hypertension* 13(2): 177–183.
- Vithoulkas George. 1998. *The Science of Homoeopathy*. New Delhi: B. Jain Publishers.

ABOUT THE AUTHORS

Dr. Kira Erwin: Dr. Kira Erwin completed her M.Phil. from Cambridge (UK) and her doctorate in sociology from the University of KwaZulu-Natal. Currently she holds a post-doctoral research fellowship at the Centre for Critical Research on Race and Identity, based at the University of KwaZulu-Natal. Her interests lie in urban ethnography, oral histories and race thinking in society, and what kinds of shifts and transformations are taking place in this regard in South Africa and elsewhere, particularly in how notions of place and belonging, as well as gender and class, intersect and intertwine with ideas of race. In addition to this research, she works on the Kenneth Gardens' community engagement and research programme where various projects are informed through research and community participation.

Dr. Monique Marks: Professor Monique Marks is currently based in the faculty of engineering and the built environment at the Durban University of Technology in South Africa. She is a registered social worker and received her doctorate in sociology from the University of Natal in South Africa. She worked as a research fellow in the Regulatory Institutions Network at the Australian National University for three years. Professor Marks is interested in issues of plural governance. She has explored this issue through the lens of security, and more recently in regard to health. She has published four books. She has also published widely in peer-reviewed journals on the areas of ethnography, youth social movements, police labour relations, and

security governance. In recent years she has become interested in the dynamics of community development and in community wellness programmes.

Dr. Ingrid Couchman: Dr. Couchman has a master's degree in homeopathy from the Durban University of Technology, where she is a lecturer in the homeopathy department. She lectures in diagnostics and clinical homoeopathy and supervises master degree students. She is also a clinician at the homeopathic day clinic at the University and has spear-headed the Kenneth Gardens homoeopathic clinic, where she is the main clinician.

The International Journal of Health, Wellness, and Society offers an interdisciplinary forum for the discussion of issues at the intersection of human physiology and the social life conditions. It is a focal point for scholarly and practice-based discussion in a time of growing public and research awareness of the relations between health and social well-being. The concept of “health and wellness” impacts all members of society, whether at a personal level in the positive senses of life-satisfaction and exhilaration, or problematically through the cost and availability of remedial healthcare. Contributions to the journal range from broad scientific, sociological, philosophical and policy explorations, to detailed studies of particular physiological and social dynamics.

As well as papers of a traditional scholarly type, this journal invites case studies that take the form of presentations of practice—including documentation of socially-engaged practices and exegeses analyzing the effects of those practices.

The International Journal of Health, Wellness, and Society is a peer-reviewed scholarly journal.

ISSN 2156-8960

