The role of ‘African Chemists’ in the health care system of the Eastern Cape province of South Africa

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Abstract

Self-medication is documented as an integral part of health care therapy in developing countries such as Ethiopia, Cameroon, Uganda and Mexico. In South Africa the types of illnesses and health problems that are referred to both traditional healers and biomedical practices have been well documented. However, very little literature exists on self-diagnosis, self-medication or sources of the medicines used for self-medication. This bias in the literature has come about largely because anthropological studies have focused on the later stages of the illness referral system when treatment is sought from a specialist for symptoms which have not responded to forms of self-medication. As a result of this, health care studies have documented the more exceptional exotic healing rituals and culturally bound syndromes of a particular society or community, and not discussed the more ordinary practices of self-medication of everyday illness. Self-medication is however an important initial response to illness and many illnesses are successfully managed at this stage. *Amayeza* stores (singular-*iyeza* store) — or ‘African chemists’ — are an important source of medicines for self-diagnosed illnesses. The current discussion focuses on the types of medicines and treatments that are obtained from *amayeza* stores without professional consultation in the Eastern Cape province of South Africa.

Keywords: traditional medicine; African chemists; self-medication; Eastern Cape province; South Africa

Amayeza esiXhosa stores (also known as *Muthi* stores)[1] can best be described as ‘African chemists’. Directly translated, *Amayeza esiXhosa* means Xhosa medicines — comprising medicine for physical illness and for culturally related afflictions. The term Xhosa medicine is used by Xhosa people to refer to traditional herbal medicines and animal artifacts used as medicines. However, these stores also carry an extensive range of commercially manufactured pharmaceuticals and Afrikaans (South African Dutch), Dutch and Oriental remedies. *Amayeza* stores are not a recent development and were already documented by Cawston in 1933. Cawston reports that a shop that he visited displayed not only herbal remedies and animal artifacts but also a large assortment of Indian medicines.

Amayeza stores frequently offer the following categories of medicines:

1. Traditional herbal medicines and animal artifacts sold either in their natural state or as remedies prepared by appropriately trained staff members. For example, *iNtelezi*, (*Gasteria bicolor*), a succulent plant very commonly purchased to protect the user from evil spirits; *Umchomo wemfene*, solidified Rock Hyrax (*Procavia capensis*) urine used to induce delivery in expectant mothers.

2. Commercialised patent brands of refined herbal and animal remedies, with modern packaging. For example, *Enyamazane*, a packaged product from Natal Herbal Suppliers, used to elicit good fortune.

3. Patented over-the-counter medicines (OTCs) prepared specifically for the African clientele. These products have modern packaging resembling that of biomedical OTCs commonly associated with formal pharmacies, however, they have culturally relevant African brand names and motifs. For example, *Muthi Abantwana* (Medicine for Children), a syrup used to treat constipation in babies.

4. Patented brands which resemble neither traditional herbal nor biomedical medicines. These products include brightly coloured viscous liquids and salts commonly purchased for culturally related needs such as protection from evil spirits and for good luck. For example, *Itshe Abelungu* (Stone of the White Man), a multicoloured salt used as a body wash to elicit good fortune.

5. Biomedical OTCs manufactured by large pharmaceutical companies. For example, Panadon, a painkiller in tablet form.

6. Dutch and Afrikaans folk remedies manufactured by local companies. These are based on old recipes brought by Dutch settlers in the 1800s. The remedies are of processed plant material and packaged in simple styles. For example, *Duiwelsdrek druppels*, a liquid marketed for stress relief but mostly used to protect children from evil spirits.

7. Eastern remedies manufactured by local companies and packaged in simple styles. They are of Indian, Japanese and Chinese origin. For example, Chinese Super Gold, an aphrodisiac in tablet form.

The reasons for the development of these different categories can only be understood in terms of the historical, political and economic influences of the time. These influences have diversified the medical needs of contemporary Africans. Historically entangled with the processes of colonization came the forceful penetration of Western medicines. Colonial and post-colonial authorities who favoured the interests of Western medicine had a strong and racist influence as they sought to discredit traditional medicinal systems as ‘typically backward’ (Dauskardt, 1991). At the same time there was contact in rural areas between European settlers and the black African population, resulting in familiarity with each other’s home remedies, hence the continued interested in Dutch remedies in *amayeza* stores.

Mass urbanization of the black population coincided with the inundation of Western medicines. After World War II, the numbers involved had begun to represent a significant consumer force (Dauskardt, 1990). This resulted in biomedical services, particularly pharmaceutical companies, trying to capture the new market. Advertising campaigns in popular African newspapers and magazines were launched to attract consumers to biomedical products and to undermine the use of traditional medicines. Consequently, urban black Africans faced a barrage of advertisements emphasizing the superiority of Western modern medicines and depicting these remedies as an essential component of a desirable urban lifestyle (Dauskardt, 1991). The traditional medical sector retaliated and adapted to the changes taking place by also advertising their products, making use of modern packaging styles and refining the contents of medicines to suit the needs of their modern consumer (Kearns, 1994).

The coexistence of diverse cultural groups in South Africa has also influenced the range of medicinal services and products offered. For example, remedies and treatments associated with Dutch and Indian influences have become widely accepted by other cultural groups. These remedies are in such great demand that, today, there are large

manufacturing companies such as Lennon Medicines and GR Medicines producing Dutch remedies and supplying them to health care outlets and chain stores countrywide.

The health care services offered by *amayeza* stores has largely been overlooked within the literature and this is largely a result of the blind spots within medical anthropology. Medical anthropology, itself a Western product, developed in the wake of Western medicine's rapid colonisation of the world from the early nineteenth century onwards. Initially modern biomedical medicine was considered to be the only type of health service available and all other forms of health care were classified as "illegal" or "deviant." These ethnocentric and Western-focused categorisations have assisted in creating simplistic dichotomies (Press, 1980) which dominated the literature until the early 1950s.

In the late 1950s, cultural anthropologists instigated an important shift that resulted in a recognition of indigenous forms of healing practices, and added a new perspective to the knowledge of health care practices, particularly those engaged in by different cultures. Later this form of inquiry came to be known as ethnomedicine, which referred exclusively to the study of non-Western medicine (Van der Geest, 1988). Unfortunately, these studies focused ethnomedicine solely on the study of folk illnesses, traditional medical systems and herbal remedies. An overemphasis was placed on the exotic healing rituals and the culturally bound syndromes of a particular society or community (Singer; Van and Pool).

Medical anthropologists in developing communities tried to rectify these biases by recording the different types of health care services utilised by communities. During this era, the studies of Janzen (1981) were hailed as the first to provide a "holistic description" of a pluralistic medical system, offering insight into the serial use of both biomedical and traditional healing practices. Medical pluralism has since been extensively used as a theoretical model by medical anthropologists (Kleinman; Helman; Janzen; Ademuwagun and Slikkerveer).

The medical pluralism model is, however, limiting in two respects. As a theoretical model, it has been preoccupied with the need to define the various existing medical systems. The definitions of traditional and biomedical medical systems have restricted the understanding of health care services and practitioners that are not conveniently placed within one or the other. For example, until recently, very few studies acknowledged traditional healers who incorporated modern pharmaceutical medicines within their treatments (Minocha, 1980). This convergence has occurred because medical systems do not exist in a vacuum — a continual adopting and adapting of medical practices occurs. It is largely this fluidity of both knowledge and medicines that has made it impossible to define all the various medical services. These drawbacks have hindered the study of health care services offered by *amayeza* stores as their services do not fit into any of the prescribed categories. Another conceptual limitation of medical anthropology has been that most health care studies have focused on the later stages of the referral system of illness management. Consequently, very little research has been undertaken on health care that does not rely on seeking professional advice. For example, a survey revealed that up to 80% of the Peruvian population who reported symptoms of illness and/or accident opted not to seek professional care (Pedersen & Baruffati, 1989), indicating that illness is largely managed at home through self-medication.

Self-medication as a form of therapy relies on obtaining access to various medicines for oneself and one's family members. At this level of health care, individuals utilize not only herbal remedies passed on from elders but also OTCs and pharmaceutical medicines. The latter are commonly obtained from commercial outlets, such as *amayeza* stores, chain stores, pharmacies and supermarkets. The former are either freely collected in their natural state or purchased from *amayeza* stores.

Context of the present study

To address the shortcomings of medical anthropology in South African medical literature, the current paper focuses on self-medication and the role that *amayeza* stores play in providing access to medicines. The research was conducted in two towns in the Eastern Cape Province of South Africa. Three *amayeza* stores were studied in detail, one in Peddie, a small town situated in the former Ciskei, and two in King William's Town, a large urban area. The Eastern Cape has high unemployment rates, up to 49.2% in rural areas and 33.6% in urban areas. In addition, the Eastern Cape is densely populated with approx. 7,000,000 people currently living there, and is one of the poorest provinces in the country (Sidiropoulos, Jeffery, Mackay, Gallocher, Forgey & Chipps, 1996).

Research methods

The research phase of this study was undertaken over a period of eight months, and used five data collection methods: questionnaires, in-depth interviews, participant observation, empirical recordings and botanical specimen collection.

A total of 120 standardised questionnaires were administered opportunistically in the three *amayeza* stores investigated (40 in each store). The questionnaires focused on obtaining demographic information of the customers of *amayeza* stores and information regarding medicines they purchased. No recorded information exists on the demographic composition of the customers of these stores, it was therefore not possible to make use of a stratified sampling method. The questionnaires were administered over a five-month period so as to obviate end-of-month and seasonal biases.

A total of 40 qualitative interviews were conducted with as wide a range of customers as possible, so as to include custodians of different knowledge of medicinal use. The customers selected represented the following categories: housewives, pensioners, unemployed, scholars, semi-skilled workers and skilled professionals. A further nine interviews were undertaken with shop owners and their assistants. Participant observation of the transactional and interactional processes between the customers and the owners and staff of the stores was recorded in all three stores. Empirical recordings of all commodities sold in the three stores were made. Seven field trips were undertaken with three users and four sellers of medicinal plants to collect botanical voucher specimens of the medicinal plants sold in the *amayeza* stores. These were identified at the Selmar Schonalnd Herbarium, Albany Museum, Grahamstown. This data provided a basis for the interpretation and understanding of the role of *amayeza* stores in health care in the Eastern Cape.

This paper presents the data from the questionnaires as well as qualitative interviews with customers.

Results

Customer profiles

Analysis of the questionnaires showed that the stores studied were frequented by a relatively even distribution of male (47%) and female (53%) customers, and cater equally to both sexes. The largest group of customers (35%) had education levels between standards five and eight. Customers were predominantly adults, particularly young and middle-aged adults, with 36% between the ages of 25 and 39 years. The treatments sold were not age-specific

as people in these age groups purchased treatments both for themselves and their families. These figures show that, contrary to popular belief, *amayeza* stores are not predominantly used by the uneducated and older generation.

Most customers belonged to a church group with only a small percentage (15%) with no church affiliation. Most churchgoers attended either one of the mainline churches (47%), for example Methodist, or an independent healing church (25%), for example Zion Christian Church. Allegiance to Christianity did not affect patronage of these stores. Most Christian Africans readily accept Christian dogma and church rituals, while also recognizing the ancestral spirits and performing ritual sacrifice to them. For the majority no contradiction exists between these two belief systems (Du Toit, 1980). Certainly, when questioned, customers did not believe that the use of these medicines challenged their religious beliefs.

Amayeza*: who uses it and what for?*

Table 1, collated from 120 questionnaires in the study site, lists the ten most frequently purchased categories of medicine within the sample data[2]. The most popular category of medicine purchased is "Protection from Evil Spirits" (28%) followed by "Preparation of Mixtures" (16%) and then "Medicines for Rashes and Complexion Problems" (14%).

Table 1. The ten most frequently purchased categories of medicine

		Purchased for					Type of medicine purchased	
Reason for purchase	Total	Self	Healers	Infant	Household	Other	Patent	Herbal
1. Protection from evil spirits	34 (28%)	10	4	17	2		29	5
2. Preparation of mixtures for resale	20 (16%)		20				10	10
3. Rashes and complexion	17 (14%)	7		4	5	1	6	8
4. Stomach complaints	13 (12%)	9		1	3		12	1
5. Chest complaints	10 (8%)	8			1	1	10	
6. Luck	10 (8%)	6	3			1	6	4
7. Did not know	5 (4%)				5			5
8. Child birth	5 (4%)	5						5
9. Kidney infection	4 (3%)	4					3	1
10. Attract love	4 (3%)	3	1				4	
TOTALS	122 (100%)	53 (43%)	28 (24%)	22 (18%)	16 (13%)	3 (2%)	80 (65%)	42 (35%)

Personal use (indicated as Self in Table 1)

A wide range of medicines is purchased for personal use. These range from treating physical ailments to culturally related needs, notably to protect oneself from evil spirits, for luck, to attract love, to cure chest complaints, assistance in child delivery, complexion problems, stomach aches and urinary infections. Medicines for protection against evil spirits are sought for infants and adults to protect them from states of vulnerability and misfortune. For most Africans good health means not only physical health but also a healthy situation in everything that concerns them. It is possible to absorb harmful elements from the environment that can cause misfortune and ill health. The environment is considered to be riddled with undesirable elements against which one needs to protection (Ngubane, 1977). Manufactured products were preferred to herbal medicines in this regard. For example, *iTikoloshe* (the Xhosa name given to a mythical creature of evil intent) and *iNkanyamba* (fat of a snake) claim a traditional origin as they have culturally appropriate brand names but are synthetic fat compounds. Traditionally animal fats were used to protect oneself or to gain access to the key characteristic of the animal whose fat is used (Hirst, 1990).

Healers

A number of medicines were purchased by practising *amagqirha*[3], faith healers or individuals with specialist curative knowledge for preparing medicinal concoctions. In most cases a wide range of products are bought to prepare remedies for their clients. Consumers, on the other hand, who medicate themselves or family members, usually buy specific products in small quantities for simple applications (Mander, 1997). The following case studies show the types of medicines purchased by *amagqirha* and faith healers.

Hans, a 48-year-old man, came into the store wearing a white laboratory coat. He is currently unemployed but he runs a small practice from his home where he treats patients suffering from serious illnesses such as cancer, HIV, high blood pressure and diabetes. He bought *Rooi-Poeier* [Red Powder], which he said he would use to treat one of his cancer patients. Hans said, "I will make incisions into the cancer patient's leg and rub the *Rooi-poeier* into them. I will also need to steam the leg with *Pin-blom* [Pin Flower], which is a medicinal plant which I collected from the veld. This will help to remove the poison which is causing the cancer. I treat my HIV patients by steaming them in medicines which I collect from the veld. I also take them to the river where I tell them to walk naked into it and ask the ancestors to cure them. The herbal medicines that I need I either collect myself or I buy them from a store in East London. I even get some sent to me from Swaziland through the post."

It is commonly claimed by healers in the study area that they are able to cure Aids and cancer although this cannot be confirmed by the authors. *Rooi-poeier* is a patent brand-name of the manufacturers *Kowie Medicines* and falls into the category of Dutch Remedies. The veld (vegetation type) that Hans refers to is the Xeric Succulent Thicket of the Eastern Cape (La Cock, Palmer & Everard, 1990).

No-Dinner is a Zionist faith healer[4] from Keiskammahoek. She is 25 years old and has a standard eight education. She is currently unemployed and divorced with two children. No-dinner spent a total of R35.00[5] on the medicines she needed to treat her patients. She said that she regularly uses herbal roots, commercial herbal remedies such as *Enyamazane* and even the brightly coloured manufactured viscous liquids of *Itshe Abelungu* — [Stone of the White Man]. Her faith encourages her to also use holy water and twisted, coloured pieces of rope to heal people. No-dinner explained that she makes use of natural herbal medicines because she is a qualified *igqirha* but could not say which of the medicines were better or more powerful as she makes use of both natural and manufactured medicines. She treats *umafufunyana*[6], tuberculosis, fits, stomach problems and pig lice[7]. She has been healing for the last three years. She charges R19.00 for a consultation, for those who can afford it, and for those who cannot she offers her services free.

It is common practice for healers to combine the role of traditional healer and Zionist faith healer (Du Toit, 1980). *Enyamazane* and *Itshe Abelungu* are processed, patent medicines which fall into the patented brands category which resemble neither traditional herbal nor biomedical medicines.

Amayeza stores are valuable resources for traditional healers and faith healers. Twenty-four percent of the medicines purchased were for resale to their patients. In these instances a wide range of medicines were purchased, including both herbal and patent medicines, disinfectants and poisonous substances. Traditional healers and faith healers stated that it was more cost-effective to purchase herbal medicines from the *amayeza* stores than to collect medicinal plants from wild populations, due to transport costs incurred to reach the rural areas. Not only was the cost considered but also the time and energy needed to collect the medicinal plant material.

Infants

Of all the treatments bought for infants, ranging from treating chest complaints, rashes and stomach aches, the most sought-after medicines are for protecting infants from evil spirits. Ngubane (1977) describes how certain medicines are taken as protective measures against possible bewitching or to avoid repetition of illness or misfortune and to ensure the infant's survival. These fears are compounded by the fact that the death rate of children under the age of two is particularly high in the area and consequently mothers feel the need to protect their children. The medicine most sought after for these requirements was not herbal but manufactured products such as *Amafuta Enjayolwandle*, *Doepa* and *Vimbela*. *Amafuta Enjayolwandle*, literally "the fat of the sea-dog (seal)"[8], is a culturally appropriate brand name promoting the concept of traditional origin. While the product resembles the animal fat traditionally used, it is a synthetic concoction. It is smeared over all bodily openings such as the infant's nose, ears and anus to seal them against the possible entry of evil spirits. *Doepa* has an offensive smell and is rubbed onto the fontanelle (*ukhakhanyi*). This is considered a susceptible point for the entrance of hazards such as the evil spirits that a child needs to be protected against (Ngubane, 1977). *Vimbela* is a manufactured product resembling neither a traditional African medicine nor a pharmaceutical brand; it is either a clear or brightly coloured substance resembling petroleum jelly that is smeared over the infant's face because it is luminous at night thereby warding off evil spirits. An additional patent brand purchased for protection from evil spirits is *Duiwelsdrek druppels*, a Dutch remedy.

Nozululo is a 32-year-old mother and housewife with a standard six education. She does not belong to any church group. Nozululo purchased *Doepa* for R2.90 and *Duiwelsdrek druppels* for R6.70 to protect her six-month-old baby from evil spirits: "I have bought these medicines because my baby is always crying and it is because she can see evil spirits. I will smear the *Doepa* onto her head and the *Duiwelsdrek druppels* over her body. My husband suggested that I try these medicines. I have already tried *Haarlemensis* [a Dutch remedy], but this did not work. I hope that using the two medicines together will help my baby."

Patent products are the most commonly purchased for infants' problems. Very few herbal medicines are given to infants, since they are much stronger and potentially dangerous to children. Only two herbal medicines were bought for infants. The most important of the two is *umThombothi*, (*Spirostachys africana* [Euphobiaceae]) a bark sold for R1.90 a piece (approx. 5 cm^2) which is considered highly effective for infants' body rashes. The other herbal medicine, *iYeza lamasi*, (*Senecio coronatus* [Asteraceae]) is taken for removing milk solids from a weaning infant's stomach.

Household members

Often medicines are purchased without consultation or advice from store owners by a third party. This indicates that decisions affecting the purchase of medicines are being made at a household level. Medicines purchased on behalf of household members (excluding infants) were for skin rashes and complexion problems, stomach complaints, protection from evil spirits and chest problems.

Tembenzi is a 17 year-old-male, with standard nine education. He bought *Itshe Abelungu* for R5.99, Cape Aloe for R2.99, Potash for R4.99, and Bluestone for R2.99. "The *Itshe Abelungu* will be taken as a purgative and the Cape Aloe for stomach cramps. I do not know what the other two are for. I have bought them for my mother. She often sends me to buy medicines for her."

Other

Miscellaneous purchases included medicines for skin problems, chest complaints and for luck. A third party, such as neighbours or acquaintances, bought these on request.

Discussion: self-diagnosis and medication

Amayeza stores provide access to a wide range of medicines for self-medication purposes. Studies conducted in developing countries have shown that the local 'pharmacy'[9] is widely used to gain access to medicines. Wolffers (1987) explains that patients use these pharmacies to save time over seeking the free, but time-consuming services offered by public health care (Wolffers; Logan and Ugalde). The services of these pharmacies are also preferred because either the owner or the staff is of the same cultural background as their customers. This ensures no cultural and language barriers. These services also offer customers/patients more control over their own treatment (Logan, 1983).

These findings have important implications as they show that African laymen are far more responsible for treating personal and family illnesses and problems than is recognised in the past literature (Hardon, 1994), which invariably places the full responsibility of diagnostic and therapeutic decisions exclusively at the level of the medical and traditional practitioners (Welsch, 1991). Current studies show that illness episodes are largely managed at home by self-medication (Pedersen & Baruffati, 1989). This is further supported by the fact that most of the consumers in pharmacies know what they want and do not seek advice (Wolffers, 1988). This case material strongly supports this conclusion. Most of the customers who came into the *amayeza* stores purchased their medicines without seeking advice, which suggests that they were familiar with these medicines. Even first-time customers felt confident enough to buy their own medicines, or on behalf of household members. There is therefore a need to officially recognize, in the literature, the level of responsibility which is assumed by unqualified individuals and household members, as they are responsible for "making nearly all the diagnostic and therapeutic decisions" (Welsch, 1991).

Self-medication is a widespread practice. All age groups and social categories are medicating both themselves and their family members by means of access to *amayeza* stores. School children who came into the stores did not buy medicines only for their families but also for themselves. Elderly people also treated themselves and indicated that they were not using a new form of therapy.

The few studies conducted on self-medication in developing countries have portrayed self-diagnosis and medication as occurring only at the level of treating physical illnesses with pharmaceuticals and OTCs (Van; Van; Criel, 1989; Hardon; Kloos and Logan). Treatments for culturally related problems have generally been portrayed as belonging to the domain of the traditional healer or shaman. The case material presented here clearly shows that individuals are diagnosing and medicating both themselves and their family members for culturally related needs such as protection from evil spirits, securing good fortune, success in business, success in examinations, ancestral appeasement and attracting sexual partners. The services offered by *amayeza* stores permits customers more choice over their treatment. It is no longer a necessity for individuals to consult a traditional healer to obtain access to these kinds of medicines because they are conveniently available from *amayeza* stores. Consumers can save time and money by not having to endure long and costly consultations with a traditional healer, a misgiving which was expressed by several customers.

Current literature portrays modern medicines as effective in relieving physical suffering. Folk remedies and traditional medicines are depicted as being more effective in treating health problems associated with culturally related needs, settling the individuals' mind and soul and easing the social and spiritual environment of the individual (Mutambirwa and Logan). However, this study shows that a large percentage of customers purchased both traditional and commercially manufactured medicines from *amayeza* stores. In many instances manufactured medicines, including Dutch and Eastern remedies, are preferred and are considered to be more effective than traditional herbal remedies for the treatment of culturally related problems and ailments. This misconception has arisen largely because the literature invariably suggests that individuals are only offered a choice between modern (biomedical) medicines on the one hand and traditional medicines from traditional healers on the other. We have however observed that the choice offered is far more diverse.

The acceptance and incorporation of the diverse range of medicines into medical care has come about through the process of indigenisation to make them more culturally appropriate. Indigenisation refers to the process whereby popular medical concepts that have developed in relation to traditional substances are now being applied to pharmaceuticals and OTCs (Mitchell, 1983). This process has allowed medicines that were traditionally foreign, such as pharmaceuticals, to be incorporated into people's knowledge and practices. This has led to the reinterpretation of their use in terms of popular medical concepts (Cosminsky, 1994). Significant attention has been given in the literature to the indigenisation of pharmaceuticals and OTC medicines (Bledsoe; Cosminsky and Etkin) but very few accounts acknowledge the acceptance of foreign medicines for purely cultural related requirements, such as certain Dutch and Eastern remedies and new brands marketed specifically for the African market.

The process of indigenisation is documented in a number of ways. For example, the Hausa in Nigeria associate the symbolic colour of red with wounds, and this has resulted in the selection of red plant medicines (which are antimicrobial and haemostatic) and also red antibiotics (Etkin & Tan, 1994). In El Salvador the criterion of identifying bitter-tasting herbal medicines for stomach disorders has been used to identify appropriate pharmaceuticals such as chloroquine, and even the camphor of moth balls (Ferguson, 1988).

We also see the process of indigenisation occurring with the Dutch, Eastern and manufactured medicines that have been incorporated to treat culturally related needs in the current study. These include *Doepa*, *Amafuta Enjayolwandle* and the synthetic fat compounds of *Tikoloshe*, and *Nkanyamba*, all for protection from evil spirits. *Doepa* is a manufactured medicine that consists of an offensive sticky substance. It is considered to be highly effective in warding off evil spirits because of its strong smell. Traditionally strong smelling medicines have been used for such protection. Similarly, genuine animal fats such as lion and seal fat, were traditionally used as protective medicines against evil spirits. The coloured synthetic fat compounds manufactured by Natal Herbal Suppliers have been indigenised and today these products are considered to be highly effective in ensuring protection from evil spirits. Traditionally herbs such as *Impepho* (*Helichrysum odoratissimum* [Asteraceae]) were burnt to facilitate certain events. The scent and smoke produced from various Indian incense sticks have been indigenised and are now used to appeal to the ancestral spirits for good fortune. Ferguson (1988) makes the important point that the introduction of pharmaceuticals into Third World countries has not produced a radical modification in beliefs regarding aetiology and diagnosis. Similarly, the introduction of these products has not altered the popular beliefs regarding aetiology and diagnosis in the study site but rather they have been incorporated to suit the needs of popular belief.

Conclusion

Amayeza stores offer a very distinctive service in the Eastern Cape. There are no other health care outlets that offer such a wide choice of medicines for such diverse ailments and problems. They are unique in that they provide access to medicines for both physical problems and for culturally bound syndromes. The medicines for the latter include traditional herbal medicines as well as a large range of modern manufactured medicines.

More than one third (35% of the total recorded) of the medicines purchased from *amayeza* stores are for culturally related needs. They are for the most part bought without seeking advice or assistance from staff members or traditional healers, indicating that individuals and household members are diagnosing and medicating both themselves and their family members. This exposes limitations in the current literature, which largely recognises self-medication as occurring only in the treatment of minor physical complaints such as common colds, fevers and stomach problems. The use of manufactured medicines for culturally related problems is common and in some cases preferred, contrary to what is portrayed by current literature. Herbal medicines as well as a wide range of Dutch, Eastern, and patent medicines are stocked for the self-medication of culturally related requirements. The latter include those of traditional origin and those that are unlike either OTCs or herbal medicines. Consequently, the notion that only herbal medicine is used for cultural related problems needs to be discarded.

The amount of money spent by each customer is modest. The medicines, particularly the manufactured brands for culturally related problems, sell for less than R5 a bottle. The OTCs are more expensive, costing approximately R12 a bottle, whereas herbal remedies which were sold still in their natural state (not prepared into a mixture), rarely cost more than R5. Prepared remedies are more expensive, ranging from R14 to R35. This is relatively inexpensive when compared to the amount charged to consult a biomedical professional, approx. R80 excluding medication. Consequently, *amayeza* stores have come to provide access to medicines that are affordable to large sectors of the community.

Amayeza stores provide a valuable service to traditional healers and faith healers. Customers at all three *amayeza* stores purchased medicines to prepare remedies to treat their own patients. The majority of medicines purchased by healers were modern manufactured medicines. This shows the extent to which the African medical system is both flexible and inclusive of a diverse range of medicines that fall outside the domain of traditional herbalism. The local healers were the greatest spenders at all three *amayeza* stores included in the study as they invariably spent between R30 and R50 at a time.

Researchers have largely ignored the services offered by *amayeza* stores because they fall outside the domain of health care service offered by traditional healers and biomedical practitioners. However, individuals do not only consult professionals for physical illnesses, nor do they exclusively consult traditional healers for culturally related problems. Many individuals treat themselves without seeking advice at all. *Amayeza* stores fulfil a vital service in this regard as they offer individuals easy access to medicines to treat themselves. This paper clearly reveals the degree of self-reliant health care in South Africa, supporting the trends described in other Third World countries. For example Reynolds Whyte (1982) notes that health care is becoming increasingly individualistic in Uganda, and Ferguson (1988) states that a reduction in the reliance on both medical practitioners and traditional healers is occurring in El Salvador.

The recent availability of prescription pharmaceuticals in the form of injections, capsules and tablets from the informal sector such as street markets and village shops in Third World countries has been documented by Ferguson; Kloos; Van and Wolffers. This, however, has not occurred to the same degree in South Africa because

government policies control the sale of scheduled pharmaceutical drugs from the informal sector. Unscheduled OTCs are, however, readily available from most chemists, supermarkets and *amayeza* stores. The local manufacture of OTCs is cause for concern because studies done by De Wet (1996) have shown that in some cases these products are not only ineffective but also harmful. Many of the products described in De Wet's study are commonly available in *amayeza* stores. The manufacture and sale of inappropriate and potentially damaging medicines should be actively discouraged (De Wet, 1996) as large companies are exploiting the poor and uneducated consumer by launching massive advertising campaigns. *Amayeza* stores in the Eastern Cape retail OTCs prepared specifically for the African clientele with culturally relevant African brand names and motifs. Patented brands purchased for culturally related needs, such as protection from evil spirits and for good luck, are the most prevalent. Very often these medicines have conflicting instructions in different languages and as a result are not used correctly (De Wet, 1998).

The State health authorities thus have a responsibility to control marketing and sales of inappropriate and potentially dangerous medicines through unauthorised channels. The demand for OTCs and pharmaceuticals will, however, continue to exist, obligating health organisations to focus their attention on improving the quality of health care offered by all sectors, not only the formally recognised bodies such as hospitals, and pharmacies, but also the commercial sector. It is therefore important that *amayeza* stores are recognised as dispensaries of health care and are incorporated into the formal health care domain. Closer collaboration with state health services would provide *amayeza* store owners with the capacity to improve the quality of health care offered by their stores and thereby to local communities with limited access to state facilities.

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