

Zimbabwean medication use in New Zealand: The role of indigenous and allopathic substances

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Over millennia, indigenous communities have developed distinct health systems and a range of medications. Many of these traditions have been disrupted, delegitimised and changed through processes of colonisation. Changes to medicative practices also occur for groups who move from their places of origin to new countries. This article explores understandings of medications and their storage and use among 4 Zimbabwean households in New Zealand. Our findings highlight some of the ways in which allopathic medications have become acculturated as familiar objects within the everyday lives and health-related practices of these households.

Groups throughout the world have long utilised their indigenous knowledge to assign meaning and respond to illness.

Understandings of the causes, diagnoses, and treatments of illness are social constructs that often differ across groups as reflections of shared cosmologies, narratives, values and norms (Castillo, 1997; Kleinman, 2004; Ryder, Yang, & Heini, 2002; Swartz, 1998). Culture enables people to formulate ways of treating and coming to terms with illness as a physical, social and cultural construct (Castillo, 1997; Helman, 2001; Ngubane, 1977). Of particular interest in this article is what happens to indigenous forms of knowledge regarding medications and health care when the groups who have developed their own medicative practices move from their homelands to another country; in this case from Zimbabwe to New Zealand. We consider the ways in which Western¹ biomedical technologies (pharmaceuticals) are embedded within daily life and kuchengetedza utano (familial healthcare practices) within four Zimbabwean migrant mhuri (households). We explore how biomedical substances are related to

householder conceptualisations of illness and medication uses (*cf.*, Swartz, 1998).

Zimbabwe lies in southern Africa and derives its name from historical stone structures, called Great Zimbabwe 'house of stones'. Zimbabwe was colonised by the British in 1890 and became independent in 1980. There are many tribal groups although the Shona and Ndebele people are the major tribes. Familial and traditional care practices are the primary means through which healthcare is conducted in Zimbabwe (Embassy of Zimbabwe, n.d.). The majority of the population live in rural areas and most of them continue to consult vanaChiremba (traditional healers) or use highly accessible and cost effective herbs for treating a range of ailments (*cf.*, Last & Chavunduka, 1986). Many believe that vanaChiremba are culturally attuned, operate within close kinship networks, build close bonds and explain illness in terms that are familiar and understandable (*cf.*, Kazembe, 2008). Traditional treatments are diverse and complex and involve some aspects of mind-body intervention and the use of animal and plant-based products (United Nations

Environment Programme, n.d.). It is not only the symptoms of the disease that are taken into account, but also psychological, sociological and mweya (spiritual) elements of patient lifeworlds (*cf.*, Waldron, this issue). The national flower of Zimbabwe, the kajongwe or *Gloriosa Superba* (Flame Lily) is a traditional medicinal plant. The tuber juice of the kajongwe is used for pain relief, to aid kurapa (healing) and to treat zvironda (bruises), colic, mudumbu (chronic ulcers) and kushaya mbereko (infertility).

Two health care and medicative traditions are in operation in Zimbabwean mhuri (households), and these reflect two differing approaches (Ross, 2010). The first is the tsika nechivanhu chedu (traditional approach) which is based on indigenous belief systems. The second is the chirunga (Western approach) which is incorporated within an allopathic medical paradigm. With the colonisation of Zimbabwe and the creation of a Westernised professional class in urban centres, negative attitudes towards indigenous medications have developed (*cf.*, Waldron, this issue). vanaChiremba (traditional healers) have been denigrated by the settler society and supplanted by Western medications and associated practices. Traditional medications were officially designated as being 'backward' and 'African medicines' (Kazembe, 2008). According to Kazembe (2008), younger generations residing in urban settings in Zimbabwe have lost contact with indigenous marapiro echivanhu (medicative practices), ruzivo (knowledge) and healthcare systems. These Zimbabweans prefer western biomedical understandings and medications. This change has its origins in colonial practices that involve the subjugation of indigenous knowledge and traditions and the legacy of successive colonial governments and missionaries who promoted the view that anything African was inferior to their own ways of responding to illness (*cf.*, Hodgetts, Drew, Sonn, Stolte, Nikora, & Curtis, 2010).

We explored New Zealand-based Zimbabwean householder understandings of medications, where these households obtain and store medications, and the cultural and familial relations that shape their use of medications. It is important to point out that whether tsika nechivanhu chedu (traditional approach) or chirunga (Western approach), medication use involves risk. Medication can be the source of unintended ill-health, particularly when substances are taken in concert, not as directed or when substances pass their used by dates (Johnson & Bootman, 1995; Lisby, Nielsen, & Mainz, 2005; McDonnell & Jacobs, 2002). Presently, we are less interested in issues of risk and more on householder understandings and uses of medications.

This is an important focus because health care reforms in many countries such as New Zealand have led to a shift in the delivery of health care away from formal places such as hospitals towards more informal domestic settings (Dyck, Kontos, Angus, & McKeever, 2005; Hodgetts, Hayward, & Stolte, unpublished). This shift transforms the home into a 'therapeutic landscape', encompassing not only practices of healing and recovery from sickness, but also those employed for the maintenance of health (Gleeson & Kearns, 2001). Medication practices, and associated understandings, form a significant component of the care practices that take place within domestic dwellings today (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished). Exploring medication practices within domestic settings reveals understandings of 'proper' usage, risk, adherence, sharing and the relationship between biomedical and traditional indigenous medications (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished; Sorensen, Stokes, Purdie, Woodward, & Roberts, 2006).

The cultural patterning of how medications are understood and used by different groups of people in their homes

presents an exciting new avenue for research. Nikora, Hodgetts, Carlson, and Rua (2011) illustrated how medications take on important culturally-patterned meanings for Maori householders, enabling them to manage illness and assert some agency over family healthcare in accordance with everyday Maori cultural practices. The present article explores how medications become acculturated into four Zimbabwean households in ways that shape the meanings and use of these technologies in accordance with existing cultural relationships and practices of care.

The Present Study

We took a broad ethnographic approach to capture the complexities and fluidity of the use of various forms of medications, including pharmaceuticals, herbs and dietary supplements (Hodgetts, Chamberlain et al., 2011). Data collection focused on four Zimbabwean households in Hamilton, New Zealand over a three week period in January 2011, using a variety of methods (interviews, photographs, diaries, mapping, material objects, media content) to capture the complex and fluid nature of popular understandings and use of medications.

The recruitment process began by approaching indigenous Zimbabwean households who were known to the first author. Pseudonyms were used in this research to protect privacy and to ensure confidentiality. Participants were informed that they could withdraw from the research at any time. The respondents are referred to in this research as the Sibanda, Rugare, Gumbo and Moyo households. The Sibanda household is comprised of four members and these include Themba a male aged 48 who is married to Ruth aged 38. The couple has two sons Rob (16) and Jack (12). The Rugare household is made up of four members who immigrated to New Zealand four years ago. Joe (43) is male and is married to Ann (39). They have two children, a girl, Rungano (17), and a boy, Tim (13). The Gumbo

family includes Mark (42) who is married to Edith (34). The couple have two children, a boy, Tongai (15) and a girl, Thembe (6). The Moyo family is comprised of two adults and three young children. Matt (42) is married to Sue (34) and they have two boys whose names are Simba (12) and Jeff (2). Molly (7) is the only girl in the family. These households contain professionals who grew up in urban areas in Zimbabwe and had jobs which enabled them to choose to access a chirunga (Western style) medical aid scheme, but who were often dislocated from tsika nechivanhu chedu (traditional systems).

The research process was carried out in four stages over a two week period: pre-data collection, initial household discussions, tasks and individual interviews and the exit interview (see Hodgetts, Chamberlain et al., 2011). All recorded research interactions were conducted in Zimbabwean and later translated into English by the first author. Contact was made frequently either through telephone calls, household visits or mobile phone texting. In the pre-data collection stage the four households were introduced separately to the research. Participants were given the option to consider the various forms of medications they consumed. During the initial household discussion stage a general conversation about medications, their meanings and uses took place. Maps were drawn of each house that illustrated the specific places where medications were normally stored. The third stage required that data be gathered by one member of each of the participating households using diaries and photographs. Participants diarised their daily encounters with medications whether within or outside of the home, workplace or through media. They also photographed medications, their storage areas and anything that they felt was relevant to the study. Each interview took approximately 50 minutes. Diary entries, photographs and the maps were used during interviews to discuss their entries, images, thoughts and reflections. In the final stage,

exit interviews were conducted. Participants reflected on the research and were asked to give any other comments which they thought may not have been discussed in the original interviews. Throughout the process, the first author took notes reflecting the nature of the discussions and emerging themes.

The analysis involved a number of steps including transforming, coding, collating, determining and organising empirical materials. We concentrated on exploring the socio-cultural life of medications and how these substances were integrated into home life, often taking on taken-for-granted status as things that belonged and which were implicated in personal histories of illness. The analysis also looked at the use and placement of medications within caregiving relationships. The main themes identified through the research were the acculturation of chirunga medications into the existing patterning of everyday household life; and the sourcing, storage and safe use of medications in the home.

Combining Chirunga (Western) and Tsika Nechivanhu Chedu (Traditional) Traditions in the Home

These households occupy a hybridised domestic space for care in which categories of knowledge are not mutually exclusive and are in actuality churned up together in the daily reproduction of cultural life (*cf.*, Blok & Jensen, 2011). Having come from middle-class and urbanised backgrounds in Zimbabwe, all four households are familiar with the biomedical pharmaceuticals that are in common use in Zimbabwean cities. They are also aware of their own indigenous traditions, but these no longer hold centre stage. The householders reported using traditional medicines when these substances are available. It is difficult to obtain these substances in New Zealand.

In defining medications, participants invoked both chirunga (Western) and tsika nechivanhu chedu (traditional) approaches. For example, Edith gave her own definition of

what she thinks medication is:

Medication is any drugs, according to my understanding, that gets given to me or prescribed by a doctor for the conditions I would be requiring the medications for. But as Zimbabweans we also have our own traditional medications, which we do not have here in New Zealand, but back home we could definitely choose either to go to a medical doctor or a traditional doctor or even to faith healers.

Edith goes on to reflect on the influence of chirunga medications over indigenous medication practices and their origins for many Zimbabweans. One reason given for the use of allopathic medications is that they are familiar internationally and can be accessed in different countries; thus providing continuity in caregiving practices across nation states. Further, householders recognise that such medications draw on and incorporate substances from indigenous traditions. This means that allopathic medications are seen as an extension of traditional knowledge and practices, rather than as a totally separate tradition. Chirunga medications have become part of the cultural landscape as medicinal objects within these Zimbabwean households.

Factors such as accessibility, affordability and trust influence family choices regarding chirunga and tsika nechivanhu chedu medications. Choosing between chirunga and tsika nechivanhu chedu medications depends on a number of factors including the cost of each type of treatment, accessibility, and knowledge of the probable effects of different treatments (Kazembe, 2008). In New Zealand, allopathic medications are cheaper and easily available. The Moyo family felt that availability and affordability of medications in New Zealand made it easier to respond to illness than when

they lived in Zimbabwe:

Ann: Medication is expensive in Zimbabwe because of the dollar issue and some people cannot afford to buy them. Even if you go to the public hospital they might not have certain drugs because they are expensive for those public hospitals to have medicines in stock. So at times you will find that you might not get the medications because of that. And if you compare with New Zealand, I think the medications are always available. Medications in New Zealand are subsidised so anyone can buy the medications unlike in Zimbabwe where they are not subsidised and it's expensive and they cannot afford most of the medications.

Both over the counter and prescribed allopathic medications were not easily obtainable in Zimbabwe. Costs were very prohibitive for those who depended on chirunga medications.

Chirunga (Western) substances were brought into households and enculturated into an existing system of relations and customs. In this way, biomedical substances became Zimbabwean cultural objects through which relationships of care and responses to illness were manifest. The taken-for-granted use of allopathic pharmaceuticals in these households was reflected in the casual snapshots of medications. Figure 1 shows chirunga medications that were in the household at the time of the research. Discussing this image sparked the following account, which reflects the taken-for-granted nature of engagements of these households with the chirunga approach in New Zealand.

Joe: I go to the doctor or if it is something minor, I go and buy the medication over the counter, say if it is a headache... I will go and get it in the supermarket. If I have a headache and I take Panadol and there seems to be no change, there might be an underlying problem so I have to visit the doctor... I wouldn't say I



Figure 1: Joe's photograph of Panadol

am doing away with traditional medications because back home I didn't visit traditional healers.

Only when the elders would give me a few herbs and I would be treated. So my first port of call is the doctors.

The routine use of allopathic medications is associated with familiarity and perceptions of scientific proof of safety. After taking medications for a period of time, people become familiar with the effects of medications on their bodies, what works and what has side effects (McClellan & Shaw, 2005). New substances and those who administer these become acculturated into daily responses to illness and to some extent relied upon for a trusted effect. As Edith stated:

I trust the medication given to me by the doctor. Because that is something that I have grown up knowing that it is there. I trust it more than the new things that I have heard of. The doctors offer services that have been proved scientifically unlike our traditional medications that some people use.

These householders were not totally convinced about the safe use of tsika nechivanhu chedu (traditional) medications. Although they continue using tsika nechivanhu chedu medications in their homes, they relied primarily on chirunga (Western) medications.

It would be misleading to infer that issues of scientific proof for effectiveness and safety are rigid points of comparison or that, in fact, these householders compare chirunga and tsika nechivanhu chedu medications in a dualistic manner. For example, Ruth gave a summary of how she viewed key differences between chirunga and tsika nechivanhu chedu approaches to treatment, which contextualise the use of medications associated with each tradition. In the process, such participants

invoke nuances and complexities around dualistic distinctions between chirunga and tsika nechivanhu chedu health systems:

Medical doctors are able to treat broken limbs. I could have surgery performed on me and be given a diagnosis of the problem. They have equipment like x-ray machinery to carry out extensive examinations on their patients and come up with an informed diagnosis. Traditional healers lack such machinery and cannot tell what is wrong with my liver for example. I am sure that they may be good at treating spiritual problems. They look at the person as a whole and have interest in a person's family or the environment surrounding the patient. Medical doctors might not be interested in all that stuff. I like them because they use scientifically proven methods of treatment and there is no guess work.

It appears that a pragmatic approach to using medications from different cultural traditions is in operation in these households. Daily medications use transcends the dualism between biomedical and traditional indigenous knowledge and substances (*cf.*, Blok & Jensen, 2011). For the householders biomedical and indigenous medications have different, yet complimentary functions. Householders proposed that the emphasis chirunga (Western) trained doctors place on treating malfunctioning parts of the body was in many respects compatible with the emphasis vanaChiremaba (traditional healers) placed on treating the whole person, including spirit aspects.

Householders were aware that biomedical constructions² present disease as a form of biological malfunction manifesting in chemical and physiological changes within the physical body (Ross, 2010). In a pure

form, the biomedical approach looks at isolated disease agents and attempts to change and control them. The approach is based in the Cartesian separation of mind and body, and separates physical illness from psychological illness (Hodgetts et al., 2010). Strictly speaking, spiritual illness does not exist according to the biomedical approach. Our participants do not accept such a rigid understanding of disease. They recognise the benefits of biomedical science where doctors used diagnostic tools like x-ray machines which helped them make informed diagnoses and prescriptions for medications. Whilst drawing on effective medications from this tradition, our participants preserved a more traditional emphasis on people that does not rely on the mind and body dualism. Emphasis is placed on looking at relationships surrounding patients. In a similar vein, Ross (2010) proposes that mind, body and spirit are part of a larger whole and no distinction is made between physical and psychosocial problems within traditional methods of healing that seek to alleviate physical symptoms and reintegrate the person with his or her community, the earth and the spirit world. This reflects writing on the development of African centred psychologies and medicine that draw on knowledge systems developed over millennia and which focus on interpersonal relations, mind, body and spirit as part of a coherent whole (see Ngubane, 1977; Waldron, this issue). It also reflects how colonial and indigenous knowledge can become interwoven within daily life.

Storing and Using Medications in the Home

Despite the broader societal context in New Zealand reaffirming the use of Chirunga (Western) medications, these households also maintained their unique way of life, daily routines and broader indigenous understanding of illness and care. An important element of this research was to consider what happens to chirunga medications once they are brought into such

culturally-patterned domestic settings. For example, where are medications stored, who administers these substances and how do these practices relate to indigenous assumptions and practices?

Women were the key dispensers of medications and regulated storage and access for the family. Ann keeps medications considered hygienic to be stored with food in the kitchen pantry because they were easily accessible and whenever she is in the kitchen she is always reminded to take them. She does the cooking and prepares her food there. Placement of medications in certain areas was done to aid all participants in remembering to take medications herself or to administer these to family members. Edith also recounted such considerations when she discussed the storage of medications in the refrigerator:

I put them in there (Figure 2) to remind myself that I have to take my medication. They are easily reachable so that if anyone is sick they can reach them. I don't keep medication in the pantry because the hot water cylinder is in the pantry. It is hot in the pantry and can alter the medication because of the heat. The kitchen cupboard is also a cooler place and that is what the medication instructions say, to be stored in a cool place. If I keep the medication in the bedroom I might forget to take them.

Our participants emphasised the need to keep the medications away from any hot spots within the home as heat could have an effect on the medications, and to store medications under certain conditions prescribed by her chirunga (Western) trained doctor. The storage and consumption of medications is implicated in the patterning of the households (Nikora et al., 2011). For example, bathrooms and bedrooms are common places where

orally-consumed medications are stored. This marks a separation between bodily functions and food consumption.

The storage of medications appears to be influenced by many factors, including their accessibility to different family members, cultural assumptions regarding hygiene and the need to remember to consume these substances and to administer them to other householders (*cf.*, Nikora et al., 2011). Medications that were ingested were stored and consumed in food eating spaces, which included kitchens and dining rooms. Externally applied and inserted medications are kept away from eating places. The exception is medications like insulin which needed to be refrigerated. Such medications are retrieved from the refrigerators and injected away from food eating places.

Most medications were administered before or after meals. Meal times functioned as reminder moments and instances when parents enact parental responsibilities, including the regulation of familial medication use. Figure 3 depicts the cultural patterning of such mundane occasions in everyday household life. During meals the

family in the picture adopt particular seating arrangements where males sit on the couch whereas females sat on the floor. The youngest in the family, Tim (13) is male, yet he is elevated to the same status as that of his father. Culturally, Tim represents his father in any family related matters in the event of his father's absence. On such occasions, parents act as mediators in their children's relationships with medical professionals, as 'prescribers' of substances, and how they supervise their children's treatment and ensure compliance with and changes to medication regimens (*cf.*, Hodgetts et al., unpublished).

Sharing medications during such communal occasions is a feature of household life today that allows family members to demonstrate care for one another and to tackle the issue of sickness together (*cf.*, Hodgetts, Chamberlain et al., 2011; Hodgetts, Nikora, & Rua, 2011). Panadol and paracetamol, as well as tsika nechivanhu chedu (traditional) medications were shared among family members. These householders were reluctant to experiment with the use of medications in familial relationships in a



Figure 2. Edith's medications stored in the refrigerator.



Figure 3. Rugare family sharing their dinner.

manner evident in the household practices identified as occurring within other cultural groups (Hodgetts, Nikora et al., 2011). As Themba states:

...unless it's been advised by the doctor. Medications like paracetamol which are just plain painkillers yes but not specific medications. After assessing you the doctor gives you maybe an antibiotic. It doesn't mean that if I have say, tonsillitis, and the doctor gives me a particular antibiotic and my wife contracts tonsillitis and she also goes to consult a doctor, it doesn't necessarily mean she'll get the same antibiotic that I was given. So for that reason, wisdom will tell us no, you go and get your own. Chances are you might be given the same, chances we will get it in different doses, so we don't share, we don't unless it's over the counter medication like paracetamol where you just walk

in and buy it.

All households were conscious of the need to adhere to a chirunga (Western) trained doctor's advice when taking prescription medications in order to ensure each family member's safety. Medications that were obtained over the counter without a prescription were considered safe to share. Through sharing these medications social relationships among the Zimbabwean households were sustained and nurtured. Culturally, parents as custodians of their children had the responsibility of sourcing medications from various places including from doctors, pharmacies and supermarkets (cf., Hodgetts et al., unpublished). The administration and safety matters of medications remained in the hands of the parents.

Discussion

Zimbabwean migration to New Zealand involves the movement of not only physical selves, but also the knowledge of groups regarding illness, treatment and care. Such movements raise questions surrounding the continuation of indigenous Zimbabwean

health-related knowledge and practices in a new place. We have begun to explore familial understandings of and socio-cultural practices surrounding the use of medications in everyday lives of four Zimbabwean households. As a key location for care, the home spaces plays an important role for maintaining each family's health as the main place where medications are stored, administered and used (Sorensen et al., 2006). In this place, the use of medication occurs within the context of householder efforts to respond to and manage illness, and to preserve their familial relationships and cultural traditions (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished). Through taking or giving others medications, people demonstrate care for themselves and others close to them (Whyte, Van der Geest, & Hardon, 2002). The consumption of material objects such as medications can also reaffirm familial bonds and culturally patterned relationships of care. Zimbabweans come from a background of interdependence where sharing, unity, respect and love dominate much of their lives. In the event that any member of their family or immediate family falls sick, they are there to support each other by sourcing a cure and making sure that the member takes the medication as prescribed by a doctor.

Within these households, medications are embedded in complex cultural, familial, social and health care relations. Householders view medications from a culturally hybridised standpoint encompassing both tsika nechivanhu chedu (traditional) and chirungu (Western) perspectives (Blok & Jensen, 2011). Although these Zimbabwean participants emphasised their use of chirungu (Western) medications in their day-to-day lives in New Zealand, these substances were transformed socially into cultural objects through their use in daily household life, particularly in parental responsibilities to care (cf., Hodgetts et al., unpublished). Both tsika nechivanhu chedu (traditional) and chirungu

medicines provided a meaningful way for families to achieve treatment objectives in daily life and the exertion of control over illness (cf., Leontowitsch, Higgs, Stevenson, & Jones, 2010).

This study has raised more questions than it has answered. We have only scratched the surface in relation to the use of chirungu medications among this indigenous group and how the presence of different cultural traditions of healthcare are integrated within everyday life in their domestic dwellings. Future research needs to contribute to the development of an indigenous Zimbabwean psychology, within the context of recent work on African indigenous psychologies (Waldron, this issue). The development of such psychologies is crucial to address the continued marginalisation of African knowledge within our discipline and the privileging of Anglo-American traditions as normative and somehow culturally free. Concepts and psychologies germane to particular groups are invaluable in understanding their healthcare practices and use of both tsika nechivanhu chedu and chirungu medicines. This article comprises a tentative contribution to this broader agenda of indigenising and pluralising psychology.

References

- Blok, A., & Jensen, T. (2011). *Bruno Latour: Hybrid thoughts in a hybrid world*. London: Routledge.
- Castillo, R. (1997). *Culture and mental illness: A client centred approach*. Pacific Grove, CA: Brook Cole.
- Dyck, I., Kontos, P., Angus, J., & McKeever, P. (2005). The home as a site for long-term care: Meanings and management of bodies and spaces. *Health and Place, 11*, 173-185.
- Embassy of Zimbabwe. (n.d.). *History of Zimbabwe*. Retrieved 2nd October 2011 from <http://www.zimembassy.se/health.html>
- Gleeson, B. & Kearns, R. A. (2001). Remoralizing landscapes of care.

- Environment and Planning D: Society and Space*, 19, 61-80.
- Helman, C. G. (2001). *Culture, health and illness*. London: Heinemann.
- Hodgetts, D., Drew, N., Sonn, C., Stolte, O., Nikora, L., & Curtis, C. (2010). *Social psychology and everyday life*. Basingstoke, UK: Palgrave/MacMillan.
- Hodgetts, D., Chamberlain, K., Gabe, J., Dew, K., Radley, A., Madden, H., & Nikora, L. W. (2011). Emplacement and everyday use of medications in domestic dwellings. *Health & Place*, 17(1), 353-360.
- Hodgetts D., Nikora, L., & Rua, M. (2011). Maori men and the indirect procurement and sharing of medications. *AlterNative: An International Journal of Indigenous Peoples*, 7(2), 152-162.
- Johnson, J. A., & Bootman, J. L. (1995). Drug-related morbidity and mortality. A cost-of-illness model. *Archives of Internal Medicine*, 155, 1949-1956.
- Kazembe, T. (2008). Some cultural aspects of traditional medicine, traditional religion, and gender in Zimbabwe. *The Rose+Croix Journal*, 5, 36-49.
- Kleinman, A. (2004). Culture and depression. *Journal of Medicine*, 10, 951-953.
- Last, M., & Chavunduka, G. (1986). *Professionalisation of African medicine*. Manchester, UK: Manchester University Press.
- Leontowitsch, M., Higgs, P., Stevenson, F., & Jones, I. (2010). Taking care of yourself in later life: A qualitative study into the use of non-prescription medicines by people aged 60+. *Health*, 14, 213-231.
- Lisby, M., Nielsen, L., & Mainz, J. (2005). Errors in the medication process: Frequency, type and potential. *International Journal for Quality in Health Care*, 17, 15-22.
- McClean, S., & Shaw, A. (2005). From schism to continuum? The problematic relationship between expert and lay knowledge – An exploratory conceptual synthesis of two qualitative studies. *Qualitative Health Research*, 15, 729-749.
- McDonnell, P. & Jacobs, M. (2002). Hospital admissions resulting from preventable adverse drug reactions. *Annals of Pharmacotherapy*, 36, 1331-1336.
- Nikora, L. W., Hodgetts, D., Carlson, T., & Rua, M. (2011). Māori and medications: What happens with the pills go home? *AlterNative: An International Journal of Indigenous Peoples*, 7(2), 87-99.
- Ngubane, H. (1977). *Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice*. London: Academic Press.
- Ross, E. (2010). Inaugural lecture: African spirituality, ethics and traditional healing – implications for indigenous South African social work education and practice. *South African Journal of Bioethics and Law*, 3, 1.
- Ryder, A. G., Yang, J., & Heini, S. (2002). *Somatisation vs psychologisation of emotional distress: A paradigmatic example for cultural psychopathology*. In W. J. Lonner, D. L. Dinnel, S. A. Hayes, & D. N. Sattler (Eds.), *Online reading in psychology and culture* (Unit 10, Chapter 2). Bellingham, WA: Center for Cross-Cultural Research, Western Washington University.
- Sorensen, L., Stokes, J., Purdie, D., Woodward, M., & Roberts, M. (2006). Medication management at home: Medication risk factor prevalence and inter-relationships. *Journal of Clinical Pharmacy and Therapeutics*, 31, 485-491.
- Swartz, L. (1998). *Culture and mental health: A South African view*. Cape Town: Oxford University Press.
- United Nations Environment Programme, (n.d.). *Traditional Medical Practices*. Retrieved 2nd October 2011 from <http://www.unep.org/>
- Whyte, S. R., Van der Geest, S., & Hardon, A. (2002). *Social lives of medicines*.

Cambridge, UK: Cambridge
University Press.

Notes

¹ We are aware of the problematic and homogenising nature of the term 'Western'. We use this term to denote developed and European dominated societies, including those in the global south. At the same time it is important to acknowledge diversity within and across European cultures.

² We acknowledge that Western medicine contains a range of biomedical, social medicine, population health and complimentary approaches. We are reiterating a distinction our participants made between the biomedical approach and their indigenous approach.

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