

**COLLABORATION BETWEEN TRADITIONAL HEALERS
AND NURSE PRACTITIONERS IN PRIMARY HEALTH
CARE IN MASERU HEALTH SERVICE AREA – LESOTHO**

BY

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I declare that COLLABORATION BETWEEN TRADITIONAL HEALERS AND NURSE PRACTITIONERS IN PRIMARY HEALTH CARE IN MASERU HSA - LESOTHO is my own work and that all the sources that I have used or quoted have been indicated and acknowledged **by means of complete references**

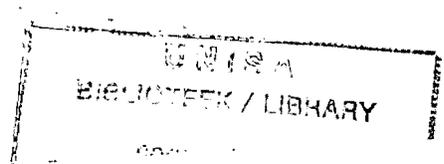
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DEDICATION

This thesis is dedicated to my late mother Julia 'Matsepiso Sello who did not live to witness the fruits of her efforts.



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**COLLABORATION BETWEEN TRADITIONAL
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PRIMARY HEALTH CARE IN MASERU
HEALTH SERVICE AREA – LESOTHO**

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SUMMARY

The purpose of the study was to explore and describe the existing relationship between traditional healers and nurse practitioners in Maseru Health Service Area in Lesotho and also to determine why people consult traditional healers. Qualitative and quantitative methods were used to investigate the relationship between traditional healers and nurse practitioners and also to determine why people utilize the services of traditional healers.

The study was limited to Maseru Health Service Area in Lesotho. Data was collected from twenty-seven (27) nurses from nineteen (19) clinics and from thirty (30) traditional healers from the same health service area. Data from traditional healers was collected using semi-structured interviews while nurse practitioners were given a questionnaire to complete.

The study revealed that there was no formal relationship between traditional healers and nurse practitioners. Support for traditional healers was revealed to be limited, for example, only four (14.8%) nurses had a programme for traditional healers while twenty (66.7%) traditional healers did not have any contact with nurse practitioners. Involvement of traditional healers in primary health care at grassroots level has therefore been very minimal.

The reasons why people utilize traditional healers were found to be as follows:

- When people think they have been bewitched.
- Traditional healers can tell the actual cause of disease
- Failure of modern practice
- For social problems.

According to the study, both traditional healers and nurse practitioners felt that collaboration between traditional healers and nurse practitioners was essential because it would enable planned referral of patients from one group to another where necessary; it would also facilitate exchange of ideas and knowledge for the benefit of the people served. Recommendations on collaboration and on support systems are given in Chapter Six.

KEY TERMS

Collaboration; culture; health; modern practitioner; nurse; primary health care; traditional healer.

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GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal clinic
AIR	Acute Respiratory Infections
CHAL	Christian Health Association of Lesotho
COSC	Cambridge Overseas School Certificate
DFL	Doctors for life
HC	Health Centre
HIV	Human Immunodeficiency Virus
HSA	Health Service Area
ICN	International Council of Nurses
LEC	Lesotho Evangelical Church
MOH & SW	Ministry of Health and Social Welfare
NHTC	National Health Training College
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
Q.E.II	Queen Elizabeth II Hospital
STDs	Sexually Transmitted Diseases
TBA	Traditional Birth Attendant
TB	Tuberculosis
UNISA	University of South Africa

USA **United States of America**
VHW **Village Health Worker**
WHO **World Health Organization**

CHAPTER 1

The purpose of this chapter is to give the reader an overview of the study. A brief description of the problem statement, purpose of the study, followed by objectives and research questions is given. A summary of research methodology as well as an overview of the chapter to follow are briefly described.

1.1 INTRODUCTION

Lesotho has adopted the 1978 Alma-Ata declaration of "Health for all by the year 2000". By signing this declaration, the government of Lesotho undertook to protect and promote the health, of its people regardless of their status. The government also saw primary health care as a means by which the health services would be made available, accessible and acceptable, at a cost affordable to the communities. Paradoxically, the programme also has to proceed alongside the government's structural adjustment programme which aims, among other things, to reduce public expenditure and to withdraw subsidies for certain programmes, including health. The structural adjustment policy thus has a negative impact on the health sector because of the reduction in public expenditure and withdrawal of the subsidies. It means the poor people, who paid reduced user fees for health services, will have to pay the full cost of the service, which may not be affordable.

The principles incorporated in primary health care, among others, include a multi-sectoral approach, team building and community involvement. These principles thus suggest the need for cooperation among those involved in health care activities. This cooperation should be between

workers as well as between health care providers themselves.

The Alma-Ata declaration marked a turning point in the approach to the delivery of health. It advocates health care that will consider seriously the rich and the poor alike; a care that will lead to the narrowing of the gap between the advantaged and the disadvantaged groups of people. The assumption is that all people, regardless of their education and social positions, need to participate in primary health care activities if the goal is to be realized. An integrated health care system, involving all groups and bringing together traditional healers and modern forms of health care, becomes a social development that bridges the existing gap between the traditional healers and the western practitioners, (Alma-Ata 1978).

Health care services in Lesotho are provided by the government, Christian Health Association of Lesotho (C.H.A.L) and traditional healers. Traditional healers provide a significant percentage of the population with health care. In a survey by Sechaba consultants (Mojji & Rojas 1993:28), 40 percent of the respondents said they would get help from the traditional healers when sick while 10 percent said they would get assistance from the spiritual healers, who are often classified by analysts as traditional healers. In another survey by the same group of consultants (Mojji & Rojas 1993:38), it was discovered that the cost of medical care is a serious problem for Basotho, implying that it is not affordable for many people. It was also noted that the numbers of people visiting the health centres are declining due to several factors, such as increasing fees and decreasing family income. The cause of a decrease in family income is a decline in mine earnings following retrenchment of mine workers. Most able-bodied men in Lesotho work in the South African mines. This has implications for the traditional ways of saving life, namely

prevention of disease, cure and rehabilitation. People who have no cash are unlikely to visit modern practitioners when they are sick, as this demands that payment be in cash.

Lesotho's traditional social system, beliefs and customs include, among others, the use of traditional healers to cure and prevent disease as well as to control the environment against harsh conditions. Thus in Lesotho, traditional healing means much more than treating human ailments.

It sometimes means controlling natural forces or influencing supernatural events. For example, Basotho believe that traditional healers are capable of preventing hailstorms, thus protecting their crops from damage. This profoundly affects the way the Basotho perceive health, illness and disease including the functions of those providing health services.

Due to social changes that have taken place over time in Lesotho, the country's traditional healers established, in 1991, an organization called Lesotho Universal Medicine men and Herbalist Council. The expectation is that all practising healers must be registered with the council. The implication here is that charlatanism is likely to be kept out of the system. According to the Lesotho Universal Medicine men and Herbalist Council' constitution (1991:1), the main aim is:

to save and protect peoples lives through curative services that relate to the tradition
(author's translation from Sesotho).

The Ministry of Health recognizes the existence of traditional healers by keeping their register. Each one of those registered traditional healers pays twenty Maluti (M20.00) for registration and license to practice which is renewable annually. However, not all traditional healers are registered; this issue was revealed during the discussion at the conference of traditional healers

held on the 4th May 1996 at Lakeside Hotel. One may argue that this recognition is an advantage to the government because efforts to open a dialogue with a system that has been a secret for a long time are nearing success. The other advantage is that this may be a form of control for entry to the profession. Traditional healers, in Lesotho, therefore, enjoy some form of state recognition as a vital element in the provision of health care and as a part of the community that needs to be considered for collaboration in primary health care (Toloane 1996).

World Health Organization (WHO) (Nursing in Support of Health for All 1981:12) notes that “nurses working as a unified force can take the lead in health care, effecting changes in the health system in order to correct the existing deficiencies and to enable people to live a productive life”. The organization recognizes nurses as a group capable of bringing positive change to the health of the people. In Lesotho, nurses are a critical component of the health delivery system as they work in areas that are hard to reach and where other professionals are not found. Thus nurses are closest to the people in rural areas. The researcher assumes that it is in recognition of this proximity to the people that WHO has extended the invitation to the nursing profession to coordinate, collaborate and expand community services. Nurses have been asked to work with traditional health workers and interdisciplinary teams to ensure preventive health care throughout the system (WHO 1981:12). The nurses’ location within the society suggests that nurses should be a vital link between the government and rural population particularly the traditional healers who are also a critical force in the health care system. It is in recognition of the above call by WHO that the researcher wished to undertake the study on collaboration between traditional healers and nurse practitioners in primary health care.

The International Council of Nurses (ICN) (1996:42) in its efforts to give support and leadership to the nursing profession has requested the nurses to renew the “Health for All strategy”. The Organization argues that:

Health for All by the Year 2000 has served as an inspirational goal for health professionals since its inception in 1978 at Alma-Ata. But, as the target date approaches, this goal is clearly not attainable in many countries, making it urgent to begin a new drive to update action plans and support country efforts. WHO has requested member states to call on decision makers, opinion leaders and the general public to take stock of the present health situation and trends to identify the main health issues for their countries.

ICN calls for all interested parties to collaborate and consult in order to develop solutions that can lead to progress. With this call, one assumes that health personnel need to tap all the resources, including traditional healers. The strategy and approach needs to be well thought out so that no single system can impose its values and beliefs on the other. The issue of collaboration between traditional healers and nurse practitioners is likely to be sensitive and will need understanding, patience and respect.

1.2 BACKGROUND

Lesotho occupies an area of 30,355 square kilometres of which three quarters is mountainous. It has about 473 kilometres of tarred roads, connected mainly to administrative centres located in

the lowlands. The rest is 2,300 kilometres of dirt road and 2,500 kilometres of tracks and footpaths. According to the population census analytical report, (Bureau of Statistics 1996:15) the population of Lesotho is 1,960,069 and 80 percent live in the rural areas (Moji and Rojas 1993:21). The topography of the country makes communication between different areas of the country difficult (see fig.3.1). Travel in rural areas is mostly on foot or horseback for those who can afford horses. Recently, because of the increase in poverty, very few horses can be seen.

1.3 HEALTH CARE SYSTEM IN LESOTHO

The government has built a network of clinics and health centres (56 in all) and Non-governmental Organizations have about 101 health centres, making a total of about 157 clinics (Gill 1994:85). The landscape is such that people still have to travel long distances before they can reach the nearest health centre. This, plus the waiting time at the clinic can discourage people to utilize the health facility. Meanwhile, traditional healers who live within the communities are easily accessible, hence they tend to be more popular than government facilities with rural dwellers. Another contributing factor to their popularity is the fact that they are members of the community in which they live. They know their clients and their problems, particularly the problems relating to cash income and lifestyles. Thus they do not insist on being paid cash. More importantly, traditional healing is sometimes done on credit or on the simple promise of payment based on the expectation that one's daughter is getting married soon. This is because a daughter's marriage is expected to bring *lobola* which is often paid in the form of cattle or cash. Traditional healers are more accessible to the population because they do not charge a fixed standard fee for their service. Sometimes the charge is influenced by whether the person has

recovered or not, or the relationship between the client and the healer or even the proximity between the two people involved. Their drugs are often given generously, for example, in a one litre bottle.

1.3.1 The Health Service Area concept (HSA)

The health services in Lesotho are organized around Health Service Areas (HSAs). According to Gill (1994:87), these are geographical areas with populations ranging from 38,000 to 225,000 people served by a Health Service Area Hospital (see annexure H). Each HSA hospital is responsible for the supervision of all health centres in its area, the training of all non-stipendiary staff, the implementation of primary health care and the provision of basic hospital services. There are nineteen Health Services Areas (HSAs) (see annexure H), eighteen are based around the hospitals and the nineteenth being Lesotho Flying Doctor Service which services twelve remote clinics (Gill 1994:87).

1.3.2 Health care problems in Lesotho

The following health demographic indicators in table 1.1 should further elucidate the brief background provided in the above section:

Table 1.1 Demographic indicators

Demographic indicators	Figures
Population in rural areas	80%
Annual population growth	2.54
Neonatal mortality	62/1000
Infant mortality	75/1000
Child mortality	148/1000
Maternal mortality	2.2/1000

Five main causes of mortality are, tuberculosis, heartlung circulation, respiratory disease, injuries/trauma and intestinal infections (Moji & Rojas 1993:34).

These mortality rates are known to be decreasing, for example the infant mortality rate was 103:1000 in the eighties. Tuberculosis has for a long time been, and still is, a killer disease. These high mortality rates need cooperative efforts to be reduced through change of attitudes. In most cases tuberculosis is referred to as *sejeso* (ingested poison) by traditional healers in Lesotho, thus sometimes misdirecting treatment. There is no doubt that Lesotho's integrated health programme will be judged by its ability or success in lowering mortality rates from their present levels. However, any such ability or success depends crucially on cooperation between the various groups involved in the provision of health services and how best the existing resources can be employed. However, the spread of modern health services, as provided by health centres, is constrained by the country's topography, which makes travel difficult. One very important

issue about modern facilities is whether people can afford to pay for their use. Literature suggests that sixty percent of the people in Lesotho live below the poverty line as indicated by Moji & Rojas (1993:24). In 1980 the estimated average income was M1000 per household per annum. The situation has been made worse by retrenchment of the miners from South Africa, as they contributed quite significantly to the economy of Lesotho. Worse still, agricultural returns have been reduced drastically because of the recent drought. Besides paying for health services, the poor people have to battle with feeding, clothing, housing and education of the children.

User fees for health services have recently increased by 100 percent from five Maloti (M5.00) to ten Maloti (M10.00) per adult and from two Maloti fifty lisente (M2.50) to five Maloti (M5.00) per child. Sechaba consultants in Moji and Rogas (1993:38) in a survey indicate that traditional healers tend to charge more for their services, a minimum of two hundred and nineteen Maloti (M219.00) while medical doctors charge thirty nine Maloti (M39.00) and nurses charge ten maloti (M10.00). According to this survey, “the advantage in using the services of traditional healers is that they charge once in the course of the disease while others are likely to charge for each visit” (Moji & Rojas 1993:38). In fact, modern practitioners are very strict on cash payment while traditional healers may accept various means of pay ranging from a chicken to a cow or even agricultural produce which an individual may have at the time. In actual terms, it seems traditional healers charge more but may be paid over time, or even when the client is cured making the payment convenient to the client.

Arguments regarding how both groups of health providers are viewed by the population as a whole are still going on, however, central to this discussion is : Which of the two groups of

healers is effective or knowledgeable in the act of healing? Indeed this remains an unsettled issue and could affect the government's efforts at introducing a collaborative health system. People who have relied on the traditional system would normally not regard modern practitioners as effective or useful and in some cases may think it is best to treat some cases in a traditional rather than in other ways. At the same time those who use modern practitioners would dismiss a traditional healer as a charlatan. Indeed traditional healers have obvious weaknesses even though this may not affect their acceptance to the community. Examples of such weaknesses are:

A five month (5/12) old baby was admitted to the hospital with generalized oedema after drinking some traditional medicine. The baby was given 15 millilitres of medicine 3-4 times a day due to insects moving inside the body following diarrhoea and vomiting. The baby was very sick with dyspnoea, dehydration and abdominal distension. He was further diagnosed as having paralytic ileus with renal failure. The condition continued to deteriorate until he died on the 03/03/95, a day later (Queen Elizabeth II Hospital records 1995).

The second example is that of a three month (3/12) old baby hospitalized with swelling of the face and a cough. The baby was taken to a local clinic where he was treated with antibiotics but did not respond to treatment. Two days later, he was taken to a traditional healer who made incisional scars and gave him medicine to drink. The baby's condition began to deteriorate with yellow eyes, dark urine and white stools. He was taken to the hospital where he was treated with antibiotics but the condition did not improve. He was referred to Pelonomi hospital in Bloemfontein where he died on the 30/5/95 (Queen Elizabeth II records 1995).

The first example indicates the weaknesses of traditional healers. The dose of the medicine given to the baby was indeed high according to the modern standards. If the baby had been referred to the health facility in time, perhaps, his life could have been saved. This last example to some extent depicts that modern practice also faces problems though no reference is made to their problems. The baby's condition may have warranted some close observation overnight so that, if the condition did not improve, then referral to another level of health care could be made immediately. Allowing the baby to go home did not give the health worker at the clinic a chance to make a thorough observation on the condition of the baby prior to referral to the hospital. The problems cited above further underscore the need for the traditional healers and nurse practitioners to work together in primary health care. Cooperation of the two groups can lead to addressing issues such as dosages of medicines and early referral to health facilities.

The examples cited above are not peculiar to Lesotho only. Other countries seem to experience similar problems. In the Sunday times of March 31st 1996, Tembisa Hospital authorities in South Africa gave a warning about the incorrect use of traditional medicine. This followed the hospitalization of a six month (6/12) old baby after taking heavy doses of traditional medicine four times daily for flu and constipation. The hospital superintendent indicated that there had been an increase of such cases.

These examples to some extent indicate the magnitude of the problems facing the communities in relation to the use of traditional medicine particularly medicine administered to the babies who can not choose the type of care they need. In modern health care institutions, health personnel often receive clients who have been to the traditional healers for treatment. While traditional

healers have been blamed for the cases such as these highlighted above, there has been no serious attempts by medical doctors and nurses to discuss the problem with traditional healers concerned. This means that the relations between traditional healers and modern practitioners are not just undefined but are also mutually antagonistic. The argument is that the problem has many contributing factors the most important is the fact that, in traditional healing, there are no set standards guiding the healers. This is because it has been impossible for the government to know what it takes to be a traditional healer.

The background given, highlights the factors which contribute to the problems facing the country. According to the Population census analytic report (Bureau of Statistics 1996:24), “the level of urbanization in Lesotho is low, compared to other Southern African countries such as Botswana, Malawi and Zimbabwe therefore, the population of Lesotho is still regarded as mainly rural”. The population thus still attaches great importance to the services of the traditional healers. It is for this reason that traditional healers are the first level of contact during illness, as evidenced by the case studies.

1.4 PROBLEM STATEMENT

The Government of Lesotho has adopted primary health care as a strategy to achieve health for all by the year 2,000. Through this strategy, the government hopes it can expand health services to meet health needs of the country’s 1,960,069 people as indicated by Bureau of Statistics (1996:6), whilst also utilizing locally available resources. One of the locally available resources, that could be considered, are the traditional healers. They are a health resource that is already

providing care at grassroots level. The majority of the country's population, particularly those residing in rural areas, is dependent on traditional healers for curative and preventive health services.

While traditional healing is not prohibited under any law, it is not accepted within the modern scientifically based medical health system. Traditional healing is generally viewed as a potential health risk by the modern health practitioners. It is therefore, not surprising that the latter have resisted collaboration with the former in the provision of health services. As a result, primary health care, seen by the government as a key strategy for achieving health for all, formally excludes the use of traditional healing and its related activities. Arguably, however, in excluding traditional healing from formal participation in primary health care, the government is denying itself, and the community, one of the critical resources that could make a significant contribution to primary health care. In addition, as the traditional healers command support among the majority of health consumers, they would, if accepted as working partners within the modern health care system, channel their clients into primary health care activities, thus making the system readily accepted by the majority of the population. They would also be used to educate the people on the information and knowledge about primary health care. However, the government's ambivalent attitude towards involving traditional healers in primary health care systems forecloses this possibility. This does not only contradict the declared policy of utilizing local resources but, also makes the sale of the programme among the country's predominantly rural people who are still dependent on the traditional forms of healing difficult or impossible.

1.5 SIGNIFICANCE OF THE PROBLEM OF COLLABORATION BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS.

The pervasiveness of, and the importance which is attached to traditional healing by the majority of the people in Lesotho is certainly a compelling reason why traditional healers or medicine men must be involved in primary health care. This will enable the government not only to ensure control, hence protection of the clients, but also to utilize them in a predictable and rational way.

Collaboration brought about by cooperation on the other hand will ensure that both sides can learn from each other, a development that can contribute to improvement in the national health service. Literature suggests that, as much as collaboration is a desired goal, it must also be realized that there are many problems related to traditional healing, as indicated by the case studies cited earlier (Troskie 1997(b):40). Some of the positive and negative sides of traditional healing have been identified by the World Health Organization's Afro-Technical Report Series no.1 (1976:4) as:

- *traditional knowledge and social usefulness, relations with those around him and understanding of social and cultural environment.*
- *modern drugs-treatment of certain diseases might become more effective and less costly.*

The positive aspects as indicated above show that traditional healers play a useful role in the society. Their strength lies in the fact that their clientele has trust and confidence in them. This is the aspect that can be exploited for the benefit of the nation. In fact, collaboration with traditional healers in primary health care as envisaged, and their participation will depend, among other things, on the confidence and trust in the traditional forms of healing. The trust and

confidence are a result, not only of their perceived skills, but also of their special relations with their clients, which may lead to minimal costs or ensure discount or credit. Another important factor is that they are part of the community they serve. Thus their relations with their patients is also personal. On the other hand, modern practitioners' relations with their clients is impersonal and business like and, to be more specific, sometimes even hostile.

Of course traditional healers have weaknesses. The weaknesses are identified by WHO (1976:5) as follows:

- *the imprecise nature of the disease*
- *lack of precision in dosage*
- *practice of sorcery and quackery*

The above analysis shows these weaknesses also can be translated into the traditional healers' sources of strength in the views of the communities. Traditionally, people tend to believe that medicine taken in large doses is likely to cure disease quicker than if taken in smaller doses, hence the tendency to use a standard cup to take traditional medicine. Some people also believe that sorcery and witchcraft are capable of protecting them against evil spirits and doings, hence these can be viewed as sources of strength by the communities. The negative aspects in the above paragraph are therefore, negative in terms of the modern practitioners' point of view. For the purpose of this thesis, the above are indeed weaknesses which are negative to primary health care regardless of whether traditional healers agree or not. This is an issue which needs careful handling so that traditional healers will not feel antagonized.

This section is concluded by highlighting the fact that the Basotho people have always valued their customs, tradition and beliefs. Among the beliefs relevant here are the use of traditional healing. Even with this strong belief in their culture, there has been room for change. It is therefore not surprising that the coming of Christianity brought a change in people's attitude towards traditional healing. Christianity associated traditional healing with witchcraft, and of course backwardness, hence the educated elite, who still valued this belief, consulted traditional healers at night, when nobody saw them, while those who were strongly influenced by Christianity totally shunned its use. As primary health care emerged, other thoughts also arose. Suggestions to utilize traditional healers as a resource in primary health care surfaced. The issues used as supporting statements are that traditional healers are nearer to the people because they live in the communities, are available and are more supportive in times of need (Gary and Warren 1991:14). Hess (1998:6) also gives a supporting statement that, "traditional healers are the first contact and front-line service provider of health services and they also help by referring patients to the modern sector".

1.6 PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the existing relationship between traditional healers and nurse practitioners particularly in the Maseru Health Service Area in Lesotho and to determine why people choose to consult traditional healers. The intention is to make recommendations which will be utilized to enhance the existing relationship so that the health of the Basotho people will be improved.

1.6.1. Aims of the study

The aims of the study are to :

- Identify the relationship between traditional healers and nurse practitioners with particular reference to the nurses working in the clinics.
- Determine the reasons why clients choose to utilize traditional healers rather than modern practitioners.
- Draw up a strategy to improve communication and understanding between health care providers and traditional healers to ensure full participation in primary health care implementation at operational level.

1.6.2 Research objectives

The objectives of the research are to :

- Determine the involvement of traditional healers in primary health care at grassroots level.
- Determine the support system between traditional healers and nurse practitioners.
- Find out why people sometimes consult traditional healers rather than modern practitioners when they are sick.
- Determine the views of both traditional healers and nurse practitioners regarding collaboration with each other.

1.6.3 Research questions

The research questions are as follows:

- In what ways are traditional healers involved in primary health care at grassroots level?
- What are the support systems available to traditional healers in primary health care services?
- Why do clients at times choose to consult traditional healers and not modern practitioners?
- What are the views of traditional healers and nurse practitioner regarding their collaboration in primary health care?

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 Collaboration

Collaboration in this research does not refer to traditional healers being part of the modern system or vice versa. It does not mean traditional healers practising in the modern setting, for this would remove them from the familiar environment that gives them the power to attract their clients, as opposed to modern institutions which are often a threat to their safety and to the safety of the patients because of their complexities in structures and systems of work.

Alma - Ata (1978:79) refers to collaboration as “mutual support for primary health care programmes consisting mainly of sharing expertise, training facilities, development of

appropriate technology and exchange of information and experience using national institutions.”

In this study, collaboration is viewed as sharing experiences, skills and knowledge by all health providers in an effort to alleviate suffering from disease and poverty. In Lesotho, the clinics and health centres are manned by the nurses. Traditional healers and the nurses both command respect in their own right, as health care providers, therefore, their cooperation can bring about success in the achievement of health for all, thus, together, much can be achieved in primary health care.

1.7.2 Culture

Germain (1992:1) defines culture as :

The way of life of a particular group of people. Cultural groups are distinguished by many characteristics, including mode of dress, language values, rules or norms for behaviour, economics, politics, law and social control, technology, dietary practices and health care.

This definition will suffice for this study.

1.7.3. Health

WHO defines health as “a state of complete physical, mental and social well-being, not merely an absence of disease or infirmity”. Leininger in George (1995:335), notes that “health is a state

of well-being that is culturally defined, valued and practised and which reflects the ability of individuals or groups to perform their daily role activities in a culturally satisfactory way". The definition by Leininger is appropriate for this study because the study is culturally based and the theoretical concept used in this study is Leininger's culture care diversity and universality which addresses culture, illness and response to illness (George 1995:335).

1.7.4 Modern practitioner

According to this study, this is a person who has been educated in a health institution for an agreed period and is authorised to work as a health worker in the country. In this study, sometimes the word modern practitioner is used interchangeably with nurse practitioner.

1.7.5 Nurse

The International Council of Nurses (ICN) defines a nurse as a "person who has completed a programme of basic nursing and is qualified and authorized in her/his country to practise nursing" (ICN census 1994:1). This definition will suffice for this study.

1.7.6 Primary health care

Various definitions have been given to primary health care, but at Alma-Ata (1978:2) primary health care was defined as :

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economical development of the community. It is the level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of continuing health care.

Fendal (1985:307) on the other hand gives a simple definition. He sees primary health care as “a mixture of curative, preventive, promotive and rehabilitative activities of a basic nature”.

For the purpose of this study, primary health care is viewed as simple measures taken by all health personnel, institutions and communities in an effort to improve the quality of life. It is based on the idea of equipping the people with knowledge, information and skills. The assumption is that people have knowledge and some skills gathered from experience in life. The extra knowledge and information from western-trained health personnel is designed to strengthen their skills in order to enable them to change habits that are detrimental to health. Knowledge of traditional medicines by traditional healers, as members of the community, also features in this definition.

1.7.7 Traditional healer

For the purpose of this study, the World Health Organization's (WHO) definition suffices.

According to Kalenge (1992:22), the organization defines a traditional healer as:

A person who is recognized by the community in which he/she lives as competent to provide health care by using vegetable, animal, cultural and mineral substances and certain other methods based on social, cultural and religious background as well as knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.

This definition implies that, for a person to be accepted as competent to practise traditional healing, he/she must be recognized by his/her potential patients as competent to provide the necessary care. Recognition is often an incentive to the practitioner to enhance his skills in order to spread his recognition thus striving for excellence in his performance.

According to Letsie (1992(b):3), traditional healers in Lesotho include:

Sangoma

These claim to have power from their ancestors, they have visions which guide them in their activities. They undergo some training in divination, curative and preventive activities.

Herbalist (Ngaka Chitja)

These learn their skills from the family and friendly herbalists.

Apostolic priest

They use salted water for treatment and also pray for their clients.

One type of traditional healer, relevant to this study, is the Traditional Birth Attendant (T.B.A). She is usually an elderly, married woman in the community who has had children and has learned delivery by observation and through assisting. She uses medicinal mixtures to strengthen the mother and baby during pregnancy and/or to ensure safety to both the mother and baby at delivery. As Molapo and Makatjane ([Sa]:17) put it, “traditional birth attendants may consult with the traditional healer, who is knowledgeable, for advice in times of difficulties”.

1.8 CONCEPTUAL FRAMEWORK

It has been suggested that culture influences the perception of illness and disease by individuals. Booyens (1991:478-479) notes that “disease, illness and health care are usually embedded in the culture of the society”. He further notes that “modern institutions, including modern medicine, in spite of their successes, are criticized for their neglect of the person in the socio-cultural context”. The suggestion is that modern practitioners, though popular, are known for ignoring the social and cultural background of those cared for. Yet in theory, modern practitioners emphasize the importance of incorporating cultural values, and beliefs of the sick, during care. Traditional or folk systems on the other hand tend to pay close attention to the background, beliefs and culture of their clients because they believe that disease is closely linked to the individual’s background and to the environment within which he/she lives. This may be one reason why some traditional healers keep some clients in their own homes whilst treating and observing them. It is in this

context that Leininger's theory of "culture care diversity and universality" was selected as appropriate in this study (Spangler 1992:30).

In her theory, "culture care diversity and universality" Leininger uses four levels whereby in the first level, she suggests that culture and social structure all influence care patterns. Level three of her model depicts the interaction between folk systems, nursing and professional systems. This model, is reflected in pictorial form in figure 1.1.

The conceptual framework (figure 1.1) symbolizes the overlapping or interaction between the folk system, nursing and other professions in the health care system. Leininger in George, (1995:335) defines professional health systems as "care or cure service offered by diverse health personnel who have been prepared through formal professional programmes of study in special educational institutions". On the other hand, folk health care is traditional or local indigenous health care or health practices that have special meanings and uses to heal or assist people. They are generally offered in a familiar home or environment with their local practitioners. Traditional healers fall within this category.

Nursing from the researcher's practical experience is concerned with caring, supporting and enabling people to adapt and cope with unmet needs. If culture, environment and social structures influence care, as indicated in the theory, nursing by virtue of its roles has a link with professional and folk systems

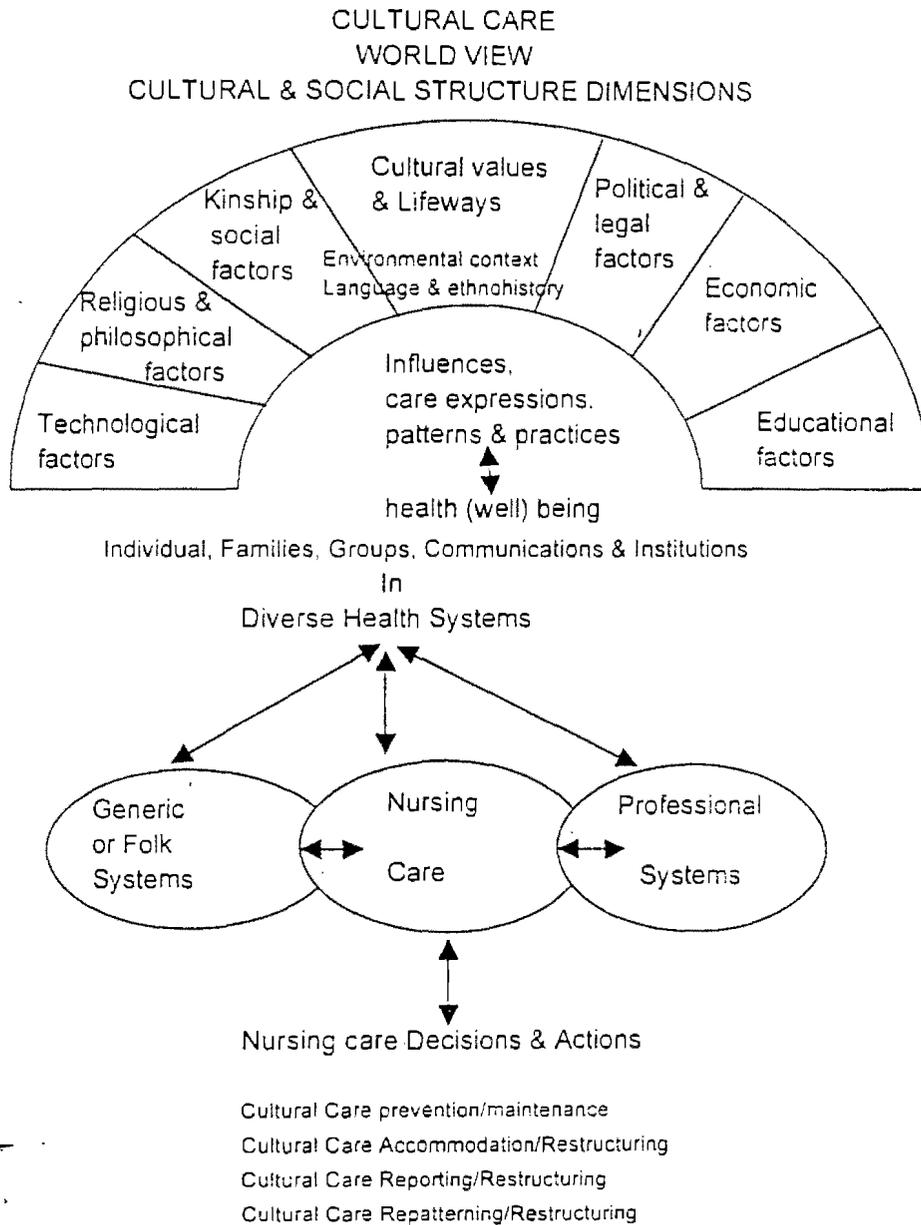


Figure 1.1: Leininger Sunrise Model to depict theory of cultural care diversity and Universality (Spangler 1992:30)

1.8.1 Assumptions from the theory

The following assumptions are given by Leininger in George (1995:390) :

- “The meaning and use of culture care concepts differs cross-culturally and influences nursing care-giver and care-receiver practices.
- There is meaningful relationship between social structures and world view with folk and professional care practice”.

According to these assumptions, as given by Leininger in George (1995:390) folk systems, traditions, customary and cultural beliefs differ from one place to another. These traditions influence the belief about causation of disease, reaction to illness and response to treatment. The assumption therefore, is that if cultural values and practices are taken into account during care, the client’s attitude towards disease and care are likely to be positive. Traditional healers live in the communities, they know the people’s cultural values and ways of living. This being the case, collaboration with traditional healers is likely to enhance quality care by reducing high morbidity and mortality. Health information can be passed from modern health practitioners to traditional healers and to the communities and from traditional healers to modern practitioners. In this context traditional healers become a channel for dissemination of health information. Health information received from influential and trusted persons, such as traditional healers may be more easily accepted and utilized to improve quality of life. Once traditional healers become a channel for communication of health matters, their skills and knowledge can be reinforced, thus adding to their expertise. Collaboration will thus benefit all.

Another assumption from this theory is that signs of conflict usually arise if care givers fail to use cultural care values and beliefs of clients (Leininger in George 1995:390). It is for this reason that dissatisfaction sometimes arises between the services of modern practitioners and those receiving care because it is rare to have their cultural values and practices included in their care. For example, the environment within which modern practitioners function and the language they use are rather complex and incomprehensible to the patient; the practitioner often spends very little time with the client, thereby leaving her/him still uninformed about the disease process and dissatisfied with the consultation. This suggests that modern practitioners still have to learn to communicate at the level of understanding of the people if acceptance is desired. On the other hand, the traditional healers function from a familiar environment with the language understood by the patient. They spend sufficient time with the patients to allow for a full explanation of the disease thereby creating a feeling of comfort in the patients. Traditional healers therefore function at the level of their patients. Their thinking and methods of treatment are compatible with the local beliefs and customs (Leininger in George 1995:390).

The theory discussed above prepares the nurses and other health workers to understand that people come for care with various cultural beliefs that need to be considered during care. Collaboration between traditional healers and modern practitioners in primary health care is therefore, a desired goal for cooperation and improvement of the health of the people. The suggested cooperation between the two systems will also give nurses the opportunity to negotiate with traditional healers, and to learn and share with them their experiences. This will lead to better health for those served. If real collaboration can be achieved, then less harmful practices will be utilized, harmful practices such as those engaged in the treatment of diarrhoea. The

traditional way of treating diarrhoea is to give a baby an enema in order to get rid of impurities. This is harmful because it often leads to increased loss of body fluids thereby leading to dehydration and death. Practices such as this need to be modified. In addition, if motivated, traditional healers will feel recognized and in turn can motivate people toward healthy life styles.

Traditional healers are observed to incorporate the cultural beliefs into the health care system. They have an understanding that cultural values, language and environment have strong influences on health care patterns and expressions as indicated by Leininger in her theory (George 1995:390). It is for this reason that this study is based on Leininger's theory of culture care diversity and universality.

1.9 SUMMARY

This chapter gives a background of the country, its health care system and the health care problems the country faces. Research objectives, questions and significance of the study are also outlined in this chapter. Leininger's theory adopted from the Sunrise model (Spangler 1992:30), culture care diversity and universality is used as a basis for this study.

1.10 OVERVIEW OF THE CHAPTERS

Chapter 2. This chapter reviews literature related to traditional healing. The literature addresses various efforts taken by countries, organizations and individuals towards collaboration of traditional healers with modern practitioners in primary health care. The literature also focuses

on the individuals and organizations which have raised contrary views towards collaboration. For any study, literature search is important for it strengthens and supports the rationale behind the purpose of research to be undertaken.

Chapter 3 looks into the methodology of the study. It also describes the approach used to obtaining permission for the study and for collecting data from the participants, preparations for the study, sampling and the actual procedure for collecting data.

Chapter 4. The data analysis of the data collected from traditional healers are analysed and discussed in an orderly manner to discern patterns and relationships. Figures and tables are used to present the findings.

Chapter 5. To impose order on the data collected from the nurse practitioners, this chapter describes the findings and gives illustrations by making use of tables and figures to assist in coming to conclusions and making recommendations.

Chapter 6. This is a concluding section of the research where the results of the study are discussed. Limitations of the study, conclusions and recommendations are presented in this chapter.

CHAPTER 2

LITERATURE REVIEW

One can find information only if one looks for it, research studies are validated through literature review.

2.1. INTRODUCTION

To help reveal the history and trends in the use of traditional medicine, a literature review was conducted. This literature search was done with the assistance of a CD ROM search of references of South African material, a CD ROM search of references of periodical articles and books, an OPAC search of references of books in UNISA, and a Library and SABINET search of references of materials in South African Libraries. The literature search was done with the help of the Subject Reference Librarian at UNISA. The literature review depicts areas which shaped this study in order to achieve the purpose of the research.

“Traditional healers are a health resource frequently relied on in the community. They are nearer to the people they serve and are knowledgeable about their patients regarding their values, beliefs as well as their behaviour” (Gary and Warren 1991:14). Traditional healers use this knowledge to influence patients’ views about illness and their attitude towards seeking help when sick (Gary and Warren, 1991:14).

Ataudo (1985:1347) notes the efficacy of traditional healers. He argues that “this is medicine of the people by the people for the people”. As a part of African philosophy, the traditional healer, according to Ataudo (1985:1347) “represents the interpreter of the unknown, the supernatural of wrong and the individual who cares about others and is involved in the problems of her/his clients and one who teaches them to believe in the Supreme Being.” These multiple roles played by traditional healers are certainly the reason why people believe in them, have trust, respect and confidence in their services.

2.2 THEORETICAL FRAMEWORK FOR THE LITERATURE REVIEW

The model identified for this study is Leininger’s theory of culture care diversity and universality. Leininger in George (1995:379) describes the purpose of the model as follows:

“To aid the study of how components of the theory influence the health status of and care provided to individuals, families, groups, communities and institutions within a culture”.

The model fits well with traditional healing because traditional healing is seen as a cultural response to avert disease and other forms of suffering in life. The model is laid down in pictorial form in Chapter one (1), Figure 1.1.

There are four levels to Leininger’s theory. In the first level, she suggests that culture and social structures all influence health care patterns. Level three of this model depicts the

interaction between folk systems, nursing and professional systems.

Leininger in George (1995:335) defines professional health systems as “care or cure services offered by diverse health personnel who have been prepared through formal professional programmes of study in special educational programmes” (George 1995:335). On the other hand, folk health care is a traditional (or local) indigenous health care (or cure) practice that has special meanings and uses to heal or assist people. It is generally offered in a familiar environment or home with the local practitioners. The traditional healers fall within this category.

Nursing as defined by Leininger in George (1995:377) is:

a learned humanistic and scientific profession and discipline which is focused on human care phenomena and activities in order to assist, support, facilitate or enable individuals or groups to maintain or regain their well being in culturally meaningful and beneficial ways, or to help people face handicaps or death (Leininger in George 1995:377).

If culture, environment and social structures influence care as indicated in this theory, nursing by virtue of its role has a link with professional and folk systems.

2.2.1 Assumptions from the theory and literature review

“There is a meaningful relationship between social structure factors and world view with folk and professional care practices” (George, 1995:390). According to this assumption, folk systems, customary and cultural beliefs differ from one place to another. These cultural factors influence the belief about causation of disease, reaction to illness and responses to treatment. It is therefore assumed that if cultural values and practices are taken into account during care, the client’s attitude towards disease and care are likely to be positive. Traditional healers live in the communities in which they work. They know the values and ways of living of their community, hence their system is likely to receive more acceptance locally than a system utilising foreign beliefs.

2.2.2 Collaboration with traditional healers and Leininger’s theory

Based on Leininger’s theory, collaboration between modern practitioners and traditional healers, who utilize the cultural factors and beliefs, could enhance quality care by reducing high morbidity and mortality rates. Health information can be passed from modern practitioners to traditional healers and to the communities, thereby promoting the traditional healers as channel for dissemination of health information.

Health information received from influential, trusted persons like the traditional healers is likely to receive acceptance in the communities. Once the traditional healers become a

channel of communication on health matters, their skills and knowledge can be reinforced, thus adding to their expertise.

2.2.3 Conflict in health care and Leininger's theory

Another assumption from Leininger's theory (Leininger in George 1995:390) is that signs of conflict usually arise if care givers fail to incorporate cultural care values and beliefs of the clients in health care. Occasionally, those receiving care from modern practitioners become dissatisfied because cultural values and customary beliefs are often not incorporated in the care given to clients. For example, the environment and the language used in modern practice can be complex and scary. People sometimes find it hard to locate which service is available where. In the researcher's experience, the practitioner often spends little time with the client, thereby leaving him uninformed about the disease process and dissatisfied with the consultation.

On the other hand, the traditional healer works in a familiar environment with the language mostly understood by the client and generally, spends more time with the patient. Some traditional healers stay with their clients in their homes while treating them to allow for full explanation of the cause of the disease, thus bringing satisfaction to the client. The thinking of the traditional healers and their methods of treatment fit well with the local beliefs and customs.

2.2.4 Negotiation by the nurses with traditional healers

Leininger's culture care diversity and universality theory prepares nurses and other health care workers to understand that people come for care with various cultural beliefs that need to be considered during care (Leininger in George 1995:390). It is assumed that cooperation between traditional healers and modern practitioners will give nurses the opportunity to negotiate with traditional healers thus enabling them to learn and share the experiences for better health for those served. Negotiation and sharing of experiences with traditional healers can be a major source of support for traditional healers as well.

2.2.5 Cultural bridge model and traditional healing

Cultural differences in the provision of health care is also noted in Leininger's theory, (Leininger in George 1995:390). Cultural differences can form a barrier to collaboration. West (1993:229), on the other hand, believes that "peaceful coexistence and a more positive cultural exchange lies in the modern practitioners and traditional healers bridging the gaps between their beliefs and values while retaining their individuality".

This implies that the cultural bridge model can be used to improve and promote healing. If individuals, families and communities have their own beliefs and values, health care practitioners must then accept the existence of and the importance of different cultures. This

can bring better understanding and acceptance between modern and traditional health practitioners in the delivery of health care systems.

West (1993:22) further notes that “this is not only a cultural issue but a political debate as well”. It is political in that politicians and members of the community have to be engaged in serious discussions, debates and negotiations if cooperation between the modern and traditional health care systems is to succeed.

Lee (1986:15) suggests that collaboration between traditional healers and modern practitioners will promote the self-care model. According to Orem in Lee (1986:15), self-care is the “care initiated and performed by individuals on their own behalf to save life and promote health”. Duval (1983:33) also supports the self-care model, postulating that the family is the health care decision making unit as evidenced by one of the informants who said: “the first thing my family does in case of illness is to rely on herbs. Of course, we will first try to use family recipes, using herbs we have at home. We might consult a Chinese doctor whose speciality is herbs”.

This supports the idea that use of traditional healing for self care even occurs in countries like the United States of America, countries whose systems are sometimes taken as models of scientific advancement. People’s willingness and ability to perform self-care need to be supported, for it is a cheaper way of maintaining health. This is not to say that people will always opt for cheaper health care. People must choose what they believe will work for

them. In addition to this, the ability to perform self-care activities promotes an individuals self-esteem, pride of being able to perform and a feeling of well being. People perceive their culture as part of them. Traditional healing is part of the culture of some societies, such as the Basotho of Lesotho, who have lived with it for a long time.

Traditional healers are observed to incorporate clients' cultural beliefs into the health care. They have the understanding that cultural values, life ways, language and environment have strong influence on health care patterns and expressions (Leininger in George 1995:335). It is for this reason that this study is based on Leininger's theory of culture care diversity and universality.

2.3 GENERAL VIEWS OF DISEASE BY BASOTHO

According to Sechaba Consultants in Moji and Rogas (1993:1), disease in Lesotho must be understood within a larger political, social and economic setting. This has several implications. Diseases are often defined and perceived in terms of societies' belief system, either poverty or at least linked to poverty. Illness has political connotations as well, to the extent that it is usually a reflection of the distribution of power or neglect on the part of politicians. Moji and Rogas (1993:19) further add that

the people of Lesotho look for what may be called deep and immediate causes of disease. Deep causes are those that relate to witchcraft and psychological anxiety,

while immediate causes are infections and injuries. Thus for deep causes, people consult traditional and spiritual healers.

This finding is revealing. It shows that over time, a dual view of health has existed among the Basotho people, the western conception of illness which is based on scientific principles, as well as one that is rooted in the traditional belief system. Ruch (1976:11) puts it more succinctly when he says: “the African today is no longer at ease, standing halfway between two contrasting cultures, not having given up his old traditions and yet not having absorbed fully the western culture”. Although this was stated in 1976, it is even more relevant today, twenty-four years later.

Ruch suggests that African people actually utilize their own traditional values in life as well as western conceptions of life. Figure 2.1 indicates that the individual will first treat himself with home remedies, and if finding no response to treatment, may then consult the family. Failing this, the prevailing circumstances will influence him/her to consult either a traditional healer or a modern practitioner. In chapter 4, item 21, nurse respondents said that people consult modern practitioners when traditional medicine has failed. Similarly, in chapter 5, item 16, traditional healers said people consult traditional healers when modern medicine has failed. It is clear that circumstances and beliefs about the disease at the time determine which practitioner to consult.

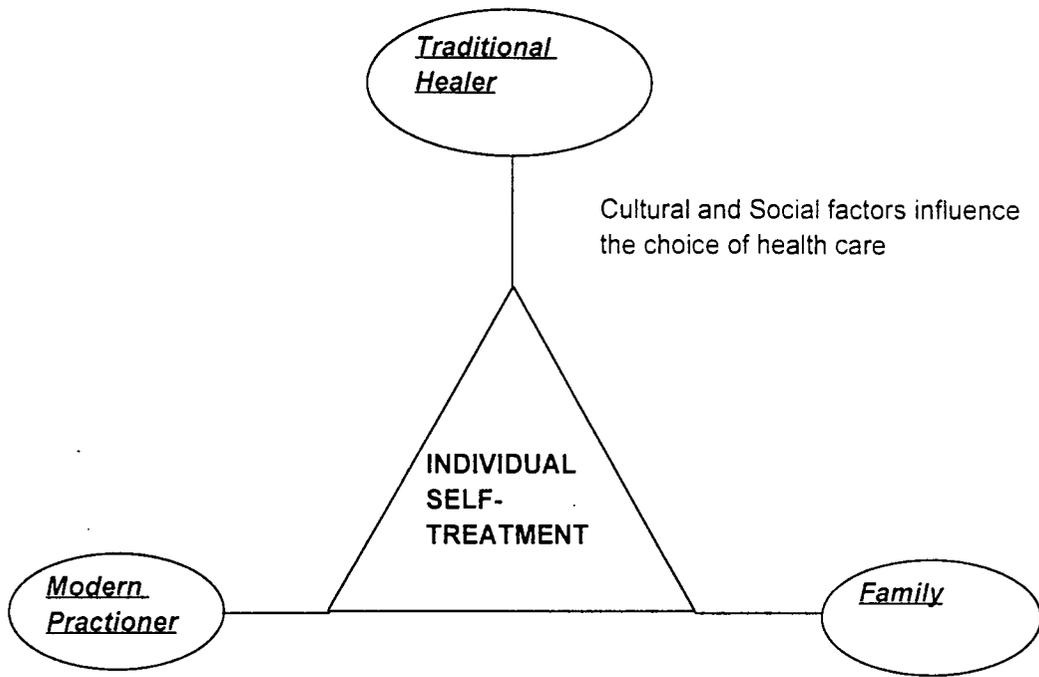


Fig. 2.1 TRIPARTITE TREATMENT

Research also reveals that utilization of medical care in Lesotho is a coping mechanism for dealing with disease. Challenges of illness force the individual to seek alternative ways of relieving suffering. According to Huss-Ashmore (1984:321), “factors which contribute to the choice of care in Lesotho during illness include the socio-demographic, economic and need variables”. These variables are accessibility of the care giver; affordability of treatment; and the seriousness and/or threat associated with disease. In his thesis, “Ashmore (1984:321) argues that “both traditional healers and modern practitioners perform various functions and none of them forms a complete coping mechanism”. In other words, the two systems complement each other depending on the type of illness and the variables mentioned above.

2.4 PRACTICE OF THE TRADITIONAL HEALER

Traditional healing is an art that is believed to have existed as early as the beginning of man’s life. According to Ruch and Anyanwa (1981:103)

Man in the world is faced with the objects which impose themselves on his senses. He tries to transform and shape it to subject its forces to his needs and wishes. He asks himself about sickness and suffering. The answers to these questions are in the environment hence he uses the herbs to cure and prevent illness and suffering.

Traditional healing is therefore a response to the challenges faced in the environment within

which man lives. The resources in the environment are used to try and explain or predict ill omen, man's relation with gods and the extent to which evil forces such as wizards or witches are responsible for man's problems.

In Lesotho, beliefs about the cause of illness become a major determinant of the type of health service sought to cure disease. Moji and Rogas (1993:19) indicate that people consult modern practitioners for diseases like asthma, rash and weak blood, whereas for diseases like alcoholism, seizure by spirits and infertility, people would go to the traditional healers.

Illness changes an individual's role, from being a parent, a housewife, a breadwinner, a family protector and a provider to adopting a "sick role." This situation brings many fears such as loss of power, strength and loss of the family. Illness also brings self-pity, poor self-esteem and reminds one of impending death. At this stage, a sick man may not know who the best healer is and in the struggle to restore his health and save his life, he may consult anybody who purports to know.

Literature suggests that traditional healing which also includes self-cure was not limited to African people but was practised by Europeans. Coetzee (1962:4) argues that "modern people do not always realize how fierce the struggle for survival was in the primitive societies where one had to rely exclusively on the resources at hand". His example of Louis Trichardt's diary may help us understand the critical situation people faced. In 1837, Trichardt's son was treated with gun powder, vinegar and aloes for fever. After perspiring,

the fever subsided. Unless there was proof that this was a self-limiting condition, one can assume that the home remedy was successful in curing the disease. There was no adverse reaction related to the treatment taken.

Europeans and Colonialists have historically seen traditional medicine as “backward” or ineffective, yet, some Europeans have recently turned to the services of traditional healers. A recent example of non-Africans utilizing traditional medicine is of Bridget and James Noble (fake names). According to the Saturday Star (January 1997), this couple believed that whilst on holiday, they and their property were protected by traditional medicine. The car escaped hijacking through the use of *tibola bead* which had traditional medicine inside and was placed behind the clutch pedal. These stories suggest some positive attitude towards traditional healing and could be used as supporting arguments for collaboration between traditional healers and modern practitioners.

2.5 COLLABORATION BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS

In considering cooperation between traditional healers and modern practitioners, it is important that each system be left with its own positive values and beliefs, where assistance can be sought and learning take places. An effort should be made to let both groups feel free to consult one another. It is a known fact that traditional healers have been here for a long time and will continue their practice. The issue of cooperation thus seems unavoidable and

necessary.

In support of cooperation, Blacket-Sliep's (1989:42-43) discussion of traditional healers and primary health care gives a list of advantages which traditional healers have. The list, though not exhaustive, includes:

- Availability. They live with the people, therefore are a resource to spread basic health needs.
- Holistic. They treat people within the context of their beliefs.
- Effectiveness. According to local people, they are successful in their approach to disease
- Cheaper. Often, there are no transport costs or very little unless it is in special cases.

These observations reveal that cooperation between traditional healers and modern practitioners in addressing health problems can be a tool for success if the above listed strengths can be exploited.

2.6 TRADITIONAL HEALERS IN MENTAL HEALTH CARE

Collaboration between traditional healers and modern practitioners in Primary Health Care is supported for other reasons. Traditional healing has been used as a peace maker among

extended family members. The belief is that disease and illness are influenced by people's relationship with ancestors and the extended family who are in their midst. According to this belief, it is advisable to have conflicts within the family resolved if harmony and health are to be achieved. Mills (1987:9) has observed that "it is the role of the diviner to mediate tensions creating disharmony, and to mobilize support from the extended family members". Conflict between the families is often explained in terms of the ancestors turning their backs upon the living due to a neglect of their wishes. It is obvious that traditional healers' skills related to this type of treatment need support, recognition and strengthening from other levels of health care, because people believe these practices are effective and have no harmful effects.

Thadebe (1991:13) suggests that mental health problems cannot be solved exclusively by one group of practitioners, but can be alleviated through a balanced combination of efforts. Kakar (1988:52) also alludes to the fact that "the co-existence of traditional medicine and modern practitioners is an indication that both of them must have done good work somehow in the cure of disease". He notes that "if people suffering from mental illness continue to approach faith healers, they must have found some psychological relief in the service of these faith healers". The above arguments put forth by Thadebe (1991:13) indicates that traditional healing and modern practice exist side by side and are both utilized by the people. This suggests that coordination of these services, and cooperation between traditional healers and modern practitioners can benefit the consumers. Cooperation can also lead to discussions and sharing of experiences that can enhance the skills of both groups and above all, the two groups can be a source of support between each other. The support between the two groups

can also lead to involvement of traditional healers in primary health care in a formal and rational way.

2.7 SYSTEMS OF RULE AND THE TRADITIONAL HEALER

Literature suggests that the Basotho have always used traditional medicine for survival. According to Casalis (1861:8), one of the early missionaries to arrive in Lesotho in 1833, Morena Moshoeshoe I (the founder of the Basotho nation) while young was taken to Mohlomi (the then healer and prophet of the nation) for consultation about his violent ways. Mohlomi instructed Moshoeshoe I in the ways of peace and just government. He made him realize that “violence did not bring lasting power”. Casalis suggests that this instruction brought stability to the young man. His stability enabled him to build the Basotho nation. The Basotho people still remember him for his diplomacy when he gave his enemies cattle for the sake of peace. This healer had not used medicine as such, but his skills in counselling indicated that traditional healers could give direction to systems of rule to secure good governance.

2.8 COMPARISON OF COST BETWEEN TRADITIONAL HEALERS AND THE HEALTH CARE SYSTEM.

Oyeneye (1985:68) observes that traditional health systems are cheaper than modern systems because most of them are paid in kind or, may be paid later when the individual has

recovered. He further notes that “the traditional healer’s training costs are lower than those of the teaching hospitals and the schools of nursing”. This also suggests that health facilities are expensive and thus inaccessible. Therefore, where traditional healers are available, they can be used to combat disease and give support during illness. Hospitals in developing countries cannot afford to keep large numbers of infected people for long periods. Because of the prevalence of HIV/AIDS, community based care has been advocated. This is an area where traditional healers would be useful. They could give the necessary support to victims of the disease and members of the family who are often physically exhausted, psychologically and emotionally worn out due to the daunting heavy task of caring for the sick. This suggests that if traditional healers can be given some training and support in preparation for home based care, they would do well in participating in primary health care (PHC) activities. Support in this case would mean, in addition to training, supervision, and perhaps supplying them with gloves for protection against HIV/AIDS whilst being involved in home based care.

Oyeneye (1985:68) further argues that traditional healers are “accepted not only for efficacy in conditions like psychiatry, orthopaedic and maternal and child health problems but they are able to offer the mystical explanation of the disease”. The Basotho people believe that if a traditional healer can find the root cause of the disease, usually a mystical explanation, then it should be easy to cure that disease. This belief also presupposes that ultimately a disease cured over a short period will cost less than a disease which takes long before it can be cured. In fact, some traditional healers often portray all diseases as easy to diagnose, therefore easy

to cure as well. It is also observed that on some notice boards, the traditional healers have written *ngaka ea mafu ohle* (A doctor for all ailments). This is perhaps similar to the practice of a general practitioner who will attempt to treat all conditions until he has been consulted about three to four times, then he can refer to the specialist. It is also important to note that hope, trust and belief in traditional doctors play a significant role in recovery from illness, notwithstanding the fact that some diseases are self-limiting.

2.9 THE IMPACT OF MODERN MEDICINE AND CHRISTIANITY ON TRADITIONAL PRACTICES

The advent of modern medical practitioners and Christianity have brought a change in the attitude and beliefs to some people in Lesotho. Christianity has discouraged some traditional values. For example, Casalis (1861:23) “clashed with the Basotho over issues such as polygamy, marriage by cattle paid to the bride by the bride groom (*lobola*), traditional healing and initiation rites”. Traditional healing was seen by Casalis as witchcraft and superstition. There has, however been a change in Christian belief. The teaching of the Christian church is now against witchcraft, not against traditional healing. According to Chavunduka (1994:24), a letter from father Oskar Wermiter, the Secretary Theological Commission of the Zimbabwe Catholic Bishops Conferences to the editor of the Herald (7th July, 1989) said:

Christians are not hostile to traditional medicine. The church has no objections in principle to traditional herbal cures either here in Zimbabwe or anywhere in the

world.....Nowadays church hospitals gladly make use of traditional midwives in their outreach work and cooperate in training them. Where a traditional healer diagnoses relationship as the cause of psychosomatic illness and heals by effecting genuine reconciliation, no one has an objection. But the church does not wish Christians to receive treatment in the course of which a traditional healer exposes someone in the community to be accused of witchcraft. Such accusations taken seriously create an atmosphere of fear, mutual distrust and as such are socially disruptive.

This reflects a change in Christian attitude in Zimbabwe and is certainly the situation in Lesotho. The clinics which belong to CHAL strongly participate in the training and utilization of village health workers (VHWs) amongst whom are traditional healers and traditional birth attendants (TBAs). The church therefore supports healing geared towards harmony and helping the sick. It is the practice of witchcraft and sorcery which the church rejects (Chavunduka 1994:24).

The need for cooperation has been recognized by the various churches. An example has been given above of how some churches in Lesotho participate in the training of traditional birth attendants. CMC- Churches Action for Health revealed in a workshop (1996:3) that

cooperation is being encouraged at a time when modern practice is experiencing major problems such as the limitations it faces in dealing with

HIV/AIDS infections as well as in dealing with many psychological problems related to the stress of modern living.

In other words, people will need joining hands to find solutions to the HIV/AIDS problem. Some traditional healers have claimed that they do cure AIDS. This claim needs follow-up to avoid loss of knowledge that could be useful to society. At the same time, consumers must not be exposed to medication that can be of no value or be dangerous to their lives, nor should those affected by HIV/AIDS have false hopes. Cooperation might help to establish reality about this claim. Drugs can be tested with traditional healers' participation to find out how effective they are. Traditional doctors' ability to diagnose HIV/AIDS infection can also be put to test with their cooperation to ensure that there is no mix of this disease with some other health problem.

2.10 RATIONALE FOR COLLABORATION AT PRIMARY HEALTH CARE LEVEL

Collaboration between traditional healers and modern practitioners in primary health care can be viewed as social integration, for it will bring traditional healers and modern practitioners closer to each other and closer to the people they serve. This is implied in Karger's (1996:12) argument. He notes that "the public good can be advanced by creating a collective social entity in which social groups understand their interdependence with each other". He further notes that:

The promotion of the public good cannot be accomplished without a form of social integration that narrows the gap between the urban newly rich, the rural population and the industrial workers.

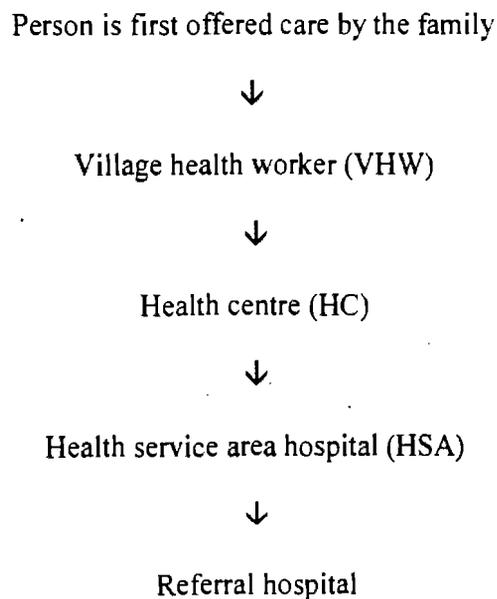
Although Karger (1996:12) does not address the issue of collaboration between traditional healers and modern practitioners, his social integration argument makes reference to interdependence as a basis for group cooperation and a tool for closing the gap between various population groups.

Primary health care can become an all embracing activity for all populations, a basis for cooperation between the rural and urban sectors and between the modern and traditional practitioners. In fact, most urban and rural communities depend on both traditional healers and modern practitioners for their health services. In Lesotho, for example, it is known from the researcher's experience that people who have been exposed to traditional healing tend to be influenced in their decisions to undergo medical treatment by their experience of both types of healing. One friend once said that "Lesotho's elite visit traditional healers at night when nobody sees them". This is because the educated elite people still associate traditional healing with backwardness and ignorance, hence they fear associating with traditional healers.

2.11 THE NURSE PRACTITIONER AND PRIMARY HEALTH CARE

From the researcher's experience, in Lesotho most of the clinics are manned by nurse practitioners, commonly referred to as nurse clinicians. Few clinics are manned by nurse/midwives. Nurse clinicians are nurse/midwives who have had eighteen (18) months training in primary health care and work in the clinics or health centres. The Community Reference Manual (1984:4) used by nurse clinicians suggests that "primary health care is the maintenance of health, prevention of illness and the treatment of illness when it does occur".

Lesotho's primary health care framework according to Community Reference Manual (1984:4) can be diagrammed as follows:



According to this framework, a person who falls sick will first be assisted by the family. If the condition does not improve, s/he will be helped by the village health worker, who will assist the patient to the health centre for a problem s/he cannot handle. The health centre will refer the patient to the health service area hospital which in turn will refer patient to the referral hospital for a more complex condition.

2.12 THE ROLE OF A NURSE PRACTITIONER IN LESOTHO

It is in the contexts of this primary health care framework that the role of a nurse practitioner can be understood. The nurse practitioner/clinician receives special training in diagnosing and treating some common ailments. These nurses also receive training in community work (Community Reference Manual,1984:7). According to the manual, “community work involves training and managing VHWs under the support of HSA staff”.

2.13 COLLABORATION AND PATIENT REFERRAL

Some traditional healers have a feeling that collaboration would be good provided such cooperation does not reduce traditional healers to mere recruiting agents for modern practitioners. During a conversation one of the traditional healers indicated that modern practitioners want traditional healers to refer patients to them, yet no patients can be referred to traditional healers by modern practitioners. Upvall (1992:34) in his study reveals that “nurses see themselves as a source of referral for traditional healers but not the reverse”.

This further underscores the mutual suspicion that exists between the two forms of healers.

Opong (1989:610) believes that the rational way to collaboration is “viewing collaboration as a two way referral system between the modern and traditional practitioners”. He further suggests that “each group could be given training on the alternative type of care available to the people”. This would enable each group to keep only those clients they think they can handle best. Opong (1989:610) suggests that education can bring the realization or awareness that both groups have a responsibility to health care, and should be given support to practice what they know best. Given the sensitivity of training, nurses could refer to traditional healers where possible.

2.14 COLLABORATION AND THE SHARING OF KNOWLEDGE BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS

Upvall (1992:34) noted in her/his study that “nurses also perceive themselves as teachers to traditional healers without learning from traditional healers”. These observations suggest that collaboration is seen by the nurses only in the sense that traditional healers have no knowledge or very little therefore, they need only to listen and be taught. This type of attitude can be a real barrier to collaboration because it does not recognize the knowledge and experience the traditional healers could have accumulated over time in their practice. Their skills and information could be an asset which, if recognized, could benefit most people. This is one of the hurdles which has to be overcome in planned collaboration. Health authorities

may have to develop guidelines, policies and procedures for collaboration. These should be done in consultation with both groups.

2.15 COLLABORATION AS A LEARNING MECHANISM FOR ALL GROUPS

It is important to view collaboration from an angle whereby all groups can learn from each other. Where areas of weaknesses are observed, these must be seen as challenges which need to be addressed to save the lives of the people. For example, a teenage boy (Saturday Star August 10th, 1996) tells of how he wanted to be a man through traditional circumcision. In his initiation group, eight boys were admitted to the hospital. Four of them had their penises amputated. One of them died while another became mentally disturbed. This situation poses a big challenge. Should traditional circumcision be left to continue uninterrupted, or should there be a dialogue with the responsible healers? Dr Kanta from the affected hospital invited the traditional healers to a meeting to discuss how the procedure could be made surgically clean (Saturday Star August 10th, 1996). This type of collaboration can be helpful to all. The people engaged in these practices need not be discouraged from the tradition which they believe in so strongly, especially when it can be modified to reduce the harmful effects. The boys with amputated penises have been rendered disadvantaged and sexually dysfunctional.

2.16 TRADITIONAL HEALING AS A PROTECTIVE MECHANISM IN THE COMMUNITY

It is noted that traditional healing can be an instrument for achieving particular desired objectives. For example, traditional medicine is normally used for protecting Basotho mineworkers in South Africa against injury or making such workers get promotions in their job. Traditional healers have also played an important role in preventing faction fights in the mines. According to Maloka (1994:196).

Basotho miners were able to develop mechanisms for coping with the depressing mine conditions. These mechanisms included consulting the traditional healers for the appropriate protective medicine before going to the mines.

The medicine given is supposed to protect the individual from his competitors who might wish to bewitch him or be promoted before him. Some of the medicine is believed to protect the individual against mine accidents. Protection against mine accidents not only applies to the miners but even to those remaining at home. Adults and the young are affected.

In real life, the experience of the researcher is that whilst young, the family traditional healer would be invited every summer to perform the family rituals and set up appropriate protective mechanisms against evil spirits and ill omen, such as lightning. Lightning is common during

the summer months and can cause death. The actual rituals included a range of activities by the traditional healer, namely making small cuts with a razor blade either on the forehead or nape of the neck or any area identified as suitable; and applying medicine, such as spraying the house and the surroundings with water mixed with herbs. Sticks and stones or reeds were smeared with medicine and placed at strategic places like animal kraals and roofing of houses for protection.

Students also seek the services of traditional doctors before they go to institutions of higher learning. Van Nierkerk in Troskie (1995:79) states that “the struggle between religion and the old practices is strong in the hearts of the people and is also problematic to the students”.

He observes that

when students go to the university, they first have to visit an isangoma to get medicine that will protect them in the new environment. When they get a degree, they become afraid of the jealousy of others who have not had the opportunity to this achievement and start to think of being bewitched. They once again visit an isangoma for further protection.

Traditional medicine is not only used to protect people from illness and misfortunes, but is used as a sanction against criminal activities. This is noted by Lucas (1995:101) in a case of a man known as Tokolosh,

a habitual drinker who was mentally disturbed and had gangrenous sores on his legs and feet which he had been told needed amputation. Although his physical condition was clearly related to his drinking, people said he became sick because he walked on medicine that was placed at his door to counteract his habit of stealing from other people in the yard.

Lucas (1995:101) further notes that traditional medicine can be used to scare people and to stop them from engaging in antisocial activities or against criminal acts which are not in line with cultural practices. This type of protection is certainly harmless, but where the skin has to be cut, those who practice it need to be given education on the use of one blade per person and be taught how the blades can be a problem. Cooperation between traditional healers and the nurse practitioners can give the nurses the opportunity to educate traditional healers on the use of new or sterilized blades.

2.17 TRADITIONAL HEALERS AS SPECIALISTS IN SOCIAL PROBLEMS

Vontress (1991:243) views traditional healers as specialists in social problems. He notes that “people go to traditional healers not for physical ailments only but mostly for reasons such as getting promotions, passing the examinations, winning a soccer game and persuading the spouse to be faithful”. These are the areas in which modern practitioners have no recorded expertise. This type of expertise is an advantage on the part of traditional healers. If such skills exist, they could be shared with modern practitioners who are willing and committed to

improve the health of people. Sharing these skills would also mean recognizing the knowledge that traditional healers have and also giving them support where necessary. Traditional healers are known for solving their problems, mainly because they know what they want and what they look for in health providers. For example, Vontress (1991:245) further suggests that “traditional healers enhance their charisma by wearing colourful attire which causes fear, promotes respect and at the same time people admire them”. This is evidence that traditional healers also are held in high regard because of their ability to exploit the forces of nature.

Dheyongera (1994:16) in acknowledging that traditional healers possess valuable knowledge, argues that “traditional healers have skills in interpersonal relations including counselling with sympathy and concern”. Kale (1995:1185) also suggests that “traditional healers are caring people, and extraordinarily skilled in counselling and psychotherapy”. He of course alludes to the fact that “others are horrible and poison their clients”. His argument is that there are lessons from which he thinks modern practitioners can learn from traditional healers. These lessons are as follows:

- *patients are completely satisfied that their symptoms are taken seriously, and that they are given enough time to express their fears*
- *the healer never considers the patient as an isolated individual but as an integral part of the family and the community*

- *the healer studies the patient as a whole and deserves credit for not splitting the body and mind into separate entities.*

In modern health practice, the above listed practices are only theories which seem difficult to implement, and in practice are rarely incorporated into the whole approach to medical care. For example, patients are normally not asked about their environment when sick, especially in physical illness. The tendency for modern health practitioners is to treat physical pain as presented by the patient, other underlying problems are often left to the relatives and the patient to attend to or to solve. This is attributed to health institution's interest in financial gain, which pressurises the nurse practitioner to do more in less time (Searle and Pera 1995:60).

2.18 CULTURE AND TRADITIONAL HEALING

Mahlaba (1992:1) notes that "culture is the backbone of the nation. Since traditional healing is based on culture, those who dismiss it as superstition lack the cultural understanding". This further underscores the notion that traditional healing being part of the culture, can function in primary health care. Primary health care may also become acceptable to people if traditional healers who are influential and respected in communities are involved.

Feierman (1995:75) also noted that in UNESCO's history in Africa, it is explained that

Africans used their religion as a weapon to resist colonial rule and its threats to their values and often relied on magic and the intervention of their ancestors in the fight against colonial oppression.

He further observes that “they dealt with epidemics, famines and other threats to life including witchcraft”. This implies that the work of traditional healing has been to protect communities against natural or manmade misfortunes.

According to literature, traditional healing is rooted in the culture of Basotho, hence they believe in its practice for their survival (Lesotho Universal Medicine men and Herbalist Council constitution 1991:1). It has been realized that “culture and other social factors have an influence in the patterns of life particularly relating to illness and health seeking behaviour during illness” (Ruch, 1976:11). Collaboration between traditional healers and modern practitioners will therefore ensure incorporation of traditional beliefs, values and customs in the health care system.

2.19 PROBLEMS OF COLLABORATION BETWEEN TRADITIONAL HEALERS AND MODERN HEALTH PRACTITIONERS

The issue of collaboration between traditional healers and modern practitioners in primary health care has been controversial. Some people have viewed collaboration as a strategy to achieve health for all, by the year 2000, while others have seen traditional healing and

modern practice as incompatible. Those who object to collaboration between traditional healing and modern practice in primary health care believe that traditional healing is guided only by superstitious beliefs and witchcraft. Other objections or criticisms to collaboration include those given by Blackett-Sliep (1989:44), who gives the following disadvantages to collaboration:

- use of herbal medicine not standardized to scientific criterion.
- easily exploited by charlatans, the poor and the uneducated fall prey to the unqualified.

2.19.1 Unsafe practices of traditional healers

In the above paragraph, Blackett-Sliep (1989:44) suggests that traditional healers are unqualified in the medical field, the result being that the poor often become the victims of malpractice. To cite one example of such malpractice, five boys whose ages ranged from 19-20 years were admitted to Queen Elizabeth II hospital (Q.E.II) in May 1997, following circumcision which was done in the traditional way. They were all septic. One of them had the entire penile skin missing; unfortunately he died in hospital due to sepsis. The other four boys were admitted with their penises partially amputated. Skin grafting was done to all of them and they were later discharged to their districts' hospitals. How these boys will later cope with sexual life remains a question to be answered. This is one example of how malpractice can be damaging to people if not curbed. It is believed that if people are given enough information, such hazards can be minimized. Information can be spread through

collaborative efforts, thus finding a way to reduce charlatanism to protect the poor and the ignorant. Dissemination of health information to traditional healers is another way to support them in their healing practice.

The South African press periodically reports instances of murder related to traditional healing. Some of the victims in one case were street children (Williams 1996:223). He notes that “these children are often cut and killed to enhance the businesses of those who have”. This horrible act is believed to be performed under the advice and guidance of the traditional healer on the notion that medicine mixed with human flesh brings luck and success in business. Williams (1996:223) notes that “the children are usually poor and abandoned, or have left their homes for reasons such as lack of love and protection from their parents”. This implies that the wealthy, abuse them out of greed. This is another area where traditional healers could be interviewed to identify harmful practices and to influence them to eliminate detrimental practices and more importantly because some of them believe that their healing practice should be kept free from activities which damage the image of traditional healing.

Chiwuzie, Ukoli, Okojie, Isah and Eriator (1987:244) who support changes in traditional practices suggest that a “prerequisite for satisfactory collaboration between traditional healers and modern practitioners is that harmful elements in traditional medicine should be abandoned”. Traditional healers on their own cannot opt to give up the practices they have adhered to for so long, on the notion that they are harmful. Some people may have to hold discussion with traditional healers to differentiate between harmful and harmless practices.

2.19.2 Witchcraft and traditional healing

One argument against collaboration between traditional healers and modern practitioners is based on the belief that traditional healers practice witchcraft and sorcery. Zungu (1992:23) notes, however, that traditional healing and witchcraft are different. He explains that “witchcraft relates to casting a spell over people, such as causing a person to be struck by lightning”. According to his notion, traditional healing requires training and knowledge, while the healer is a ceremonial leader and Psychologist.

The belief in witchcraft and its practice has resulted in animosity and misunderstanding in some communities. For example, in the researcher’s experience in one village in Lesotho, a fifteen (15) year old girl died in the hospital after a long illness. On the night of the vigil (two weeks later), the relatives of the girl claimed that the girl was bewitched therefore she was not dead. The traditional healer was invited and he confirmed the notion that the girl was not dead (a community member who lives in the village). The body was sent to the hospital for re-examination through the advice of the chief in the village. The hospital confirmed her death (Hospital records, April, 1997). This indicates how belief in witchcraft can disrupt peace and cause psychological trauma to those already undergoing stress. A body that had been lying in the mortuary for two weeks could certainly not be alive. In this episode other people in the village were already being pinpointed as responsible for the death of the girl. It is apparent that no peace will ever exist between the suspects and the relatives of the girl; if it does it will come after a very long time.

Witchcraft as a suspected practice of traditional healers continues to be an important news item in South Africa as well. One such item appeared in the Sunday Times (December 10th 1995). This described a situation in Kwazulu-Natal where the burial of eleven children who died in a bus crash was delayed for several weeks because their colleagues would not allow the burial to take place, claiming that they were bewitched. At the same time two elderly women had been killed on the suspicion that they were responsible for the bus crash. In another incidence in the Northern Province in South Africa (Sunday Times City Metro, October 20th 1996), a man's house was burned down by attackers who labelled him a wizard. In Nelspruit (Saturday Star, November 25th 1995), the police were in conflict with members of the community over employing a sangoma to clear the area of witches. In their intervention, the police condemned the strategy because the members of the community had already beaten one woman who was suspected to be a witch.

Witchcraft and sorcery are certainly incompatible with the norms of modern practice because they often engender hatred and animosity among the people who live together, thus destroying the basis for community collaboration and cooperation. Suspected witches/wizards are frequently tormented, as per examples already given above, and traditional healers are often responsible by pointing fingers at the suspects in the event of illness or death. Primary health care in itself cannot end witchcraft or sorcery, but it can certainly act as a neutralizing force to change traditional beliefs which are detrimental to people's lives, including the Basotho. As mentioned above, some good work is being done by traditional healers. But major problems do exist which need to be addressed vigorously to

save the lives of the more vulnerable, most of whom are poor and powerless, lacking resources to protect themselves from harmful practices.

If stories told about witchcraft are true, witchcraft has no place in primary health care unless efforts are made by all concerned to convert witchcraft to a useful practice. This will depend on how possible it is to identify the witches and how willing these witches are to change their attitudes.

2.20 HEALTH CARE SYSTEMS AND COLLABORATIVE HEALTH CARE

Attempts by WHO to encourage collaboration have been resisted by organizations and individuals. While opponents of collaboration (Doctors for Life, in Van Eeden 1993:442, and Swift and Strang 1993:690-691) have varied reasons for their opposition, the letter cited at length below adequately highlights the intensity and resoluteness with which the opponents have campaigned against collaboration between traditional healers and modern practitioners in primary health care. The letter from Doctors for Life (DFL) in Van Eeden (1993:441-442) express their concerns as follows:

Since we started investigating the matter, we have been flooded with evidence of unhealthy and dangerous practices of healers. More than one woman has described how she had to collect menstrual secretions, debris from under her nails and take it to the herbalist, who mixed it with herbs. The whole concoction had to be put in the husband's food to improve the

marriage relations. We are told of the traditional healers growing rich out of the medicine containing among other things pieces of baboon meat, and there has been numerous muti-murders where parts of human body are removed for medication.....we therefore oppose incorporation of traditional healers into our health system. Unless if the complete contents of their medicine are made available for a complete testing in a laboratory.

The letter contains information that is indeed alarming and should be a cause for concern. Swift and Strang (1993:691) also hold similar views. They feel that isangomas (who are also traditional healers) are unsuitable as AIDS educators because the beliefs which they hold are difficult to change. One of these beliefs is that “promiscuity could be treated by a ritual involving pushing a string of beads into the anus of very young children”. The question is whether these dangerous practices should be left as they are among the communities. These issues remain a challenge to the communities, interested parties and health professionals. The researcher believes that health care professionals have a responsibility to protect people against malpractice. They also have a responsibility to assist the people in making healthy choices by giving them adequate information. Similarly, traditional healers must be instructed on how to avoid unhygienic practices. This may not be as simple as it seems. This may require a lot of negotiation between both parties, including engagement of various educational techniques. DFL in Van Eeden (1993:442) has suggested establishing laboratories for testing medicines used by traditional healers. WHO has suggested similarly an “Institute for Traditional Healers and Natural Product Research” (Akerele 1989:1).

Analysis of these medicines by laboratories could include identifying the contents of the medicine, using guidelines to judge efficacy quality and safety for use.

2.21 THE LACK OF SUPPORT FROM GOVERNMENT POLICIES

Other problems related to collaboration are attributed to governments policies. It has been observed in various countries that governments can slow progress in collaboration between modern and traditional healers in PHC. According to Anyinam (1987:807), “the continued lukewarm attitudes of the many governments towards ethno medicine partly explains the slow progress”. Governments’ attitudes towards collaboration can influence both sectors towards a positive move. Quaye (1996:43) notes that

Government support and recognition of the importance of the role of traditional medical practices will go a long way towards removing the secretive and unhygienic labels associated with traditional medical practice.

The support can come through various activities, such as legislation addressing traditional healers, negotiating forums and, to some extent, financial support for traditional healers, who often feel they have very little support from governments.

In Lesotho, however, there has been a clearer vision though not much has been done in the line of collaboration between traditional healers and modern practitioners in PHC. The

Ministry of Health and Social Welfare (MOH & SW) Sector Plan (1995/6-1999/2000) has clearly outlined the Ministry's policy in relation to traditional practitioners. According to this sector plan, MOH & SW "observe that traditional healers respond to cultural, social and psychological problems of the people, hence, the value, trust and respect placed on the traditional healers". The sector plan of the Ministry of Health and Social Welfare (1995/6-1999/2000:75) further suggests that "the potential for cooperation between traditional healers and modern practitioners is not being fully exploited". The targets of the MOH & SW in policy relation to traditional medicine are:

- To collaborate with traditional healers in order to determine the role of traditional medicine in the health sector and to create a dialogue between the two systems.
- To increase the knowledge and understanding of traditional medicine.

The strategies for achieving these targets have been set out as follows to:

- minimise the secrecy about traditional medicine.
- organize an inventory of natural products used in traditional medicine.
- conduct research in the area of traditional health services.
- train and mobilise traditional healers to support essential primary health care services such as maternal and child health.

This policy looks attractive if it can work, but the process has been very slow despite the direction that has been set.

2.22 COMMUNICATION AND SECRECY AS A PROBLEM IN TRADITIONAL HEALING

Msothi (1992:7) notes that traditional healing “is too secretive, most of the information is private and it is not readily passed to other people therefore, knowledge is not completely shared unless if it is under agreed training conditions”. However, no mention is made about whether modern practitioners have any problems related to collaboration with traditional healers. This issue needs to be explored in order to determine if both groups can function in harmony. Koumare (1983:29) notes that

there is a gap between traditional healers and modern practitioners, the result of which has been poor communication and the lack of exchange of information between the two sectors, mutual suspicion and mistrust including open attacks against each other.

In the researcher’s experience, one of the consequences of this is that patients who have visited any of the two systems prior to consulting the other often conceal their medical history for fear that it may not be received favourably. Some health workers have asked questions which are interpreted as hostile by the clients, thus leaving them with feelings of

pain and guilt. Some of these questions include:

- Why have you come late to the health facility?
- Why did you consult the traditional healer?

These types of attitudes are likely to frustrate efforts at collaboration. They have slowed down the process of primary health care acceleration in Lesotho which the government felt was the key to the achievement of health for all by the year 2000 (Alma-Ata 1978:5).

2.23 MISTRUST BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS

Crawly (1992:10) in his argument on the problems of collaboration between traditional healers and modern practitioners suggests that “there is also a deep distrust of modern medicine’s curative and restorative capacity”. This suggests that some people still doubt the capability of modern practice to cure disease, promote or rehabilitate sick people to near healthy situations. De Jong (1991:10) further observes that “collaboration between the two systems is frustrated by strong prejudice against traditional healers”. The attitude is motivated by genuine feelings of mistrust between the two systems. Mistrust can emanate from the feelings that one group is not quite knowledgeable in the field of healing, or may feel that it is being undermined. If at all there is a feeling that the other system is engaging in malpractice,

then denying collaboration which could offer opportunities for learning and sharing is an injustice to the community.

2.24 PROBLEMS OF ATTITUDES IN THE COLLABORATION BETWEEN TRADITIONAL HEALERS AND MODERN PRACTICE

Bishaw's (1990:72) study on the attitudes of traditional healers and modern practitioners indicates that "some traditional healers thought that cooperation was impossible due to the vast differences in knowledge and beliefs". The study also suggests that there is no mutual respect between the two systems. The same study revealed that modern practitioners were unwilling to cooperate with traditional healers because of their lack of interest in them and their lack of time due to heavy work loads. Health workers are often few in numbers and overworked. As a result, any attempt to require extra activity on their part is usually not readily accepted (Bishaw 1990:72). Health centres in Lesotho are usually manned with one nurse clinician or nurse midwife and one nursing assistant. The activities in health centres include curative services, immunizations, ante-natal and post-natal care, family planning and village health worker (VHW) training. This scenario definitely reflects work overload for one registered nurse. This situation is bound to breed in them a negative attitude to expanding nurse's roles.

2.25 COMPETITION BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS

Green (1988:1127) has also observed problems in the collaboration between traditional healers and modern practitioners. He sees “economic and prestige competition between the two sectors” as a major impediment to collaboration. Mosiiman (1984:18) also observed that coexistence and competition commonly occur between traditional healers and modern practitioners in Botswana. It is obvious that where there is competition, there is little chance of cooperation because each one struggles to win the support and allegiance of the client, especially where money or any form of assets are involved. This argument is supported by a saying in Lesotho which says “*ha ho hapuo a likhomo ha ho tsehisano*”. This translates closely to “where competition is involved, issues of friendship cannot take precedence over issues at stake”. Yet it should be noted that competition is not entirely possible where there are differences in the two knowledge systems. They differ in aspects such as the educational background, professional preparation and practice. Moreover, clients know who to consult, when, and for what reasons. For example, De Jong (1991:5) suggests that people tend to consult modern practitioners for infections and acute diseases. Other conditions such as those relating to psychological and social disruptions, and those caused by organisms which have become resistant to modern drugs, are left to the services of traditional healers.

Traditional healers engage in healing for a living. One may also argue that traditional healers practise healing for other reasons. For example, one interviewee said that she could gain

social recognition by giving treatment to patients for free (based on the premise that the ancestors have instructed her not to charge anybody) or by accepting payment in alternative forms. This approach can definitely enhance recognition in the community as well as attracting people, thus becoming famous.

In most cases traditional healers practise healing for economic reasons. They compete with their colleagues and with modern practitioners. This can certainly be a factor in their decision to join or reject the suggested collaboration in primary health care. Collaboration will undoubtedly have implications for their profession as well as for their capacity to gain wealth. For this reason, their practice may require close monitoring, including disclosure of information pertaining to aspects of healing that are crucial to the credibility and survival of their profession.

2.26 PROBLEMS OF MEDICINES USED BY TRADITIONAL HEALERS

Lobadie (1986:222) attributes resistance to collaboration to drugs the traditional healers use. He notes that “drugs used by traditional healers have problems of a specific nature relating to the status of their technology, production and quality control”. Lobadie (1986:222) further suggests that traditional medicine in “general represents a poorly explored field of research in terms of therapeutic potential or clinical evaluation”. The implication is that scientific studies have to be made on the efficacy, components and preparation of traditional medicine if sceptics are to be convinced of its usefulness.

2.27 PROBLEMS RELATED TO MANAGEMENT OF PATIENTS IN HOSPITALS

According to Troskie (1995:24), traditional healers have problems collaborating with hospitals. Traditional healers “resent the manner in which the nursing staff handle the patients who are not clean”. She suggests that “the humiliating way in which these patients are addressed such as they smell bad is unacceptable”. This suggests that the nursing staff have no empathy for patients, and as a result, they have a tendency to ridicule and dehumanize them. On the other hand Troskie (1995:24) notes that problems preventing western practitioners from collaborating with traditional healers include “giving overdosage of drugs to patients, malpractice, negligence and delay in referring patients”.

In Lesotho, problems of ill-treatment and inefficiency of hospitals, especially in the national referral hospital, are often cited. In the researcher’s experience, the Lesotho media often refers to hospital staff as neglecting the patients. On the other hand, the Ministry of Health and Social Welfare sector plan (1995/6-1999/2000:63) attributes the problems of poor patient care to “inadequate bed space, lack of equipment, manpower shortage and negative attitudes to the public and to work”.

The issue of collaboration and referral has caused much debate. However, weaknesses in health care systems, such as overdosage, malpractice, negligence and delay in patients’ referral may be corrected by cooperation and education, both of which could give the

opportunity to traditional and modern health sectors to share information and to support each other.

2.28 CONTRIBUTION BY WHO TOWARDS COLLABORATION BETWEEN TRADITIONAL HEALERS AND MODERN PRACTITIONERS

WHO has been a leading authority in health issues in the world. Through WHO's efforts, small-pox was eradicated and other major health problems resolved. WHO is currently spending large sums of money in research including research for combating HIV/AIDS. Many countries therefore, rely heavily on WHO for assistance and guidance on health issues. WHO's guidelines on collaboration between traditional healers and modern practitioners can be of benefit to many countries. In this regard Akerele (1987:177) notes that "WHO plays an important role in the development and expansion of traditional medicine". He suggests that

WHO is fulfilling its constitutional responsibility to act as the directing and coordinating authority on international health as a result this organization is mandated to ensure that what is of value in the traditional system of medicine is made use of in the health services.

Some of these guidelines laid down by WHO (1990:2) are:

WHO is aware that many elements of traditional medicine are beneficial, but others are not, and some are definitely harmful. In this respect the organization encourages and supports the countries to identify and provide

safe and effective remedies, and practices for use in the public and private health services. However, this does not amount to blind endorsement of all forms of traditional medicine. WHO undertakes to support member states in their efforts to formulate national policies on traditional medicine; to study potential usefulness of traditional medicine, investigation of efficacy and safety of remedies to upgrade the knowledge and skills of traditional and modern practitioners and to educate and inform the communities about proven traditional health practices.

WHO in support of collaboration between traditional healers and modern practitioners in primary health care supported the visit to Lesotho by Akerele in July, 9-11th, 1989. According to Akerele (1989:1), the purpose of the visit was to “briefly review the situation of traditional medicine in Lesotho”

Despite the efforts taken, there has not been a very clear direction on the way forward and on the implementation of the Government of Lesotho’s policies on WHO’s guidelines for collaboration with traditional doctors.

2.29 EFFORTS MADE BY LESOTHO TO INCORPORATE TRADITIONAL HEALING INTO PRIMARY HEALTH CARE

Lesotho long realized the role played by traditional healers in primary health care, and the

need for their (traditional healers) participation in various forums that address health issues. In the first primary health care workshop held in 1978 (MOH & SW Primary Health Care Report, 1978), the Ministry of Health invited thirteen (13) traditional healers to participate. This symbolized their acknowledgement that traditional healers exist and contribute to health care. On the other hand, the invitation gave traditional healers hope that they would get the necessary support from the government and the health teams in their efforts to deliver health care. At the workshop, strategies that could be taken to strengthen primary health care activities were discussed. A series of activities between the MOH & SW and traditional healers followed and various Ministers of Health maintained contact with traditional healers. This contact, gave direction and support to traditional healers. For example, in an address to traditional healers on May 4th 1996, former Minister of Health S. Toloane recognized the important role played by traditional healers. He emphasized the need for them to develop themselves in order to acquire knowledge about disease prevention and cures. This type of contact can encourage collaboration between the two systems of health care. Some individual nurses at local clinics are also running training programmes for traditional healers. This has not been standardized, training may differ between individual clinics, but it is definitely the needed support which can assist to enhance primary health care activities.

2.29.1 Training of traditional birth attendants (TBAs)

Among the efforts taken by Lesotho to incorporate traditional healers into PHC was the training of TBAs. The training was first conceptualized in 1978. According to interviews

with Mrs A. Lephoto (a health worker who oversaw TBA training), the concept was developed jointly by the country's three (3) Health Service Areas (HSAs), namely, Scott, Roma and Mafeteng (Tsakholo area). It is worth noting that the first two HSAs belong to the Christian Health Association of Lesotho, while the latter belongs to the government. This suggests that CHAL observes the existence of traditional healers.

The main concern of these HSA's was that not all pregnant women seen at the ante-natal clinics delivered their babies at these clinics or hospitals. For example, out of one hundred (100) women seen at the ante-natal clinic (ANC), only 30 percent of them delivered their babies at the clinics or hospitals. The questions which were asked included the following:

- *What happened to the rest of these women?*
- *Where do they deliver their babies?*
- *What is the survival rate of both the mothers and the babies?*
- *Of those babies and mothers who did not make it at or after birth, could this have been avoided? (Interview with Mrs Lephoto May 1995).*

These questions did not generate satisfactory answers but were central to the development of the concept of traditional birth attendance. Formal training was established for lay people involved in deliveries in their communities. The purpose of this training was to ensure a safe clean delivery and high risk screening for women who choose to have their babies delivered at the community level. It must also be noted that traditional birth attendants are either

traditional healers, or work closely with traditional healers who provide medicine to the pregnant women to cure in case of illness or to ensure safe pregnancy and delivery (Molapo and Makatjane [Sa]).

2.29.2 Training of traditional healers

Lesotho has not been unique in its efforts towards collaboration between traditional healers and modern practitioners. Other developing countries have also demonstrated that collaboration between traditional healers and modern practitioners is a desired approach to the achievement of health for all. For example, Gort (1989:1000) reports that rural health motivator and oral rehydration programmes were designed with the traditional healers as participants in Swaziland. These programmes were said to be successful. Abdool (1993:423) also notes that attempts to incorporate traditional healers into formal health service have achieved some degree of success at the Valley Trust in Natal. Traditional healers were observed to be more efficient as community health workers after training. According to Hogle and Prins (1991:71), Ghana, Nigeria and Kenya have achieved some success by designing educational programmes which improved overall hygienic conditions, the treatment of malnutrition and the promotion of immunization.

Troskie (1995:29) provides the example of the Turn Table Trust and the Valley Trust in Kwazulu-Natal, who have given traditional healers facilities to use as traditional pharmacies. Herbs and animal matter are sold to traditional healers, who in turn use them for the treatment

of disease. She further notes that “the patients with tuberculosis who default in taking treatment have declined since collaboration with traditional healers was initiated” Ramesh and Hyma (1981:496) also refer to India as one of the more successful countries in promoting collaboration between traditional healers and modern practitioners. India is described as

having 500,000 practitioners of traditional medicine and their qualifications range from university doctorates, through certificates awarded in private schools, to skills and knowledge acquired after several years of apprenticeship to established practitioners (Ramesh & Hyma 1981:496).

The idea here is not to modernize traditional medicine but to offer an opportunity for traditional doctors to decide what is most beneficial to people. This example suggests that traditional healing certainly satisfies some need in Indian society.

2.29.3 Research programmes in Lesotho

While the Government of Lesotho recognizes the importance of collaboration between traditional healers and modern practitioners, and of research programmes in traditional healing, the government has not been enthusiastic to support sponsorship. Indeed Letsie (1992a) (a medical practitioner) has shown interest in collaboration between the two systems but has not been very successful in his efforts. He had encouraged more research towards obtaining efficacy, safety and effectiveness of some traditional preparations, for conditions such as epistaxis, burns, wounds, common cold, skin disease, diabetes mellitus and

hypertension (a letter written to the ethical committee (1992a) 12th July). Research in these areas would provide more insight into how these conditions are treated with traditional medicine. It could also be a starting point in assessing and analysing the efficacy of traditional drugs in clinic settings.

2.29.4 Registered traditional healers in Lesotho

In 1991 the registered traditional healers were estimated at 8,795 (Moji & Rojas 1993:41). It is currently assumed that the figure given, has increased, taking into consideration those who are not registered and the rate at which the practice is proliferating. Most traditional healers operate from their own homes.

In some areas in Lesotho, collaboration has begun at a smaller scale. For example, in Mokhotlong and Molepolole districts, some traditional healers have cooperated with health workers in distributing condoms to combat HIV/AIDS and other sexually transmitted diseases (WHO Quarterly Bulletin in Lesotho 1994:6). If this motivation could spread to other districts within the country, these health problems could be minimized.

Aware of the increasing numbers of traditional healers in the country and the many people who utilize their services, the MOH&SW in Lesotho has realized the need to bring them closer to other health care providers in order to enhance primary health care activities. The participation of traditional healers in primary health care can be one of the strategies to

accelerate the achievement of health for all. Although these efforts are being made, modern practitioners have not been aggressively approached about their attitudes towards collaboration between traditional healers and modern practitioners. Efforts need to be directed at both sides so that no section will feel imposed upon by another. Acceptance and commitment on both sides can play a major role in the success of primary health care activities utilizing both systems.

2.30 SUMMARY

This chapter has highlighted the issues related to how Basotho people view disease and traditional healing. This type of health care is part of their culture, and it seems as if it will continue because people strongly believe in it. Individuals, groups and organizations cited have identified problems and advantages related to collaboration. There are conflicts over barriers to collaboration between traditional healers and modern practitioners. These conflicts require serious attention by traditional healers, modern practitioners, patients and the public if health for all is to be achieved. If poverty (which plays a major role in the choice of health service to consult during illness), morbidity and mortality are to be addressed in Lesotho, the issue of collaboration needs to become a national issue.

Despite the identified problems, various countries including Lesotho have made some efforts towards collaborating with traditional healers. Many people continue to suffer because of the parallel health care delivery patterns. This makes it essential that a call be made towards

cooperation. Governments and other health providing systems can no longer afford to be indifferent to this need. It is hoped that the anticipated cooperation will strengthen what is good for the people and discard what is dangerous for health. For example much suffering brought by torture and killings related to witchcraft as cited in this chapter can be addressed strongly through a concerted effort with the traditional healers and modern practitioners, if cooperation is supported.

This chapter has also addressed the issue of opening the doors for meaningful referral from one system to another. Cooperation can also open the way to learning which can assist the people to unlearn what is dangerous. Cooperation though difficult to achieve is believed to be essential by many people quoted in this chapter.

Literature in this chapter has revealed very little involvement of traditional healers in PHC. Support between traditional healers and nurse practitioners has been minimal especially in Lesotho. Only training of TBAs has been noted. Some countries such as Ghana, Kenya, Swaziland, Zimbabwe and some areas in South Africa (Turn table Trust and Valley Trust) have succeeded in giving support to traditional healers in various forms such as training and offering traditional healers facilities to use as pharmacy.

METHODOLOGY

Scientists work with samples rather than with populations because it is more economical to do so (Polit & Hungler 1993:175)

3.1 INTRODUCTION

In order to solicit the views of traditional healers and nurse practitioners on the issue of collaboration between traditional healers and modern practitioners in primary health care, both qualitative and quantitative studies were conducted. For this research, qualitative methods were used to collect data from the traditional healers while quantitative methods were used to collect information from the nurse practitioners.

3.2 RESEARCH OBJECTIVES

The research objectives were to:

- Determine the involvement of traditional healers in primary health care at the grassroots level.
- Determine the support system between traditional healers and modern practitioners.
- Find out why people sometimes consult traditional healers rather than modern practitioners when sick.
- Determine the views of both traditional healers and nurse practitioners regarding collaboration with each other.

3.3 RESEARCH DESIGN

Exploratory qualitative and quantitative methods were used in this study to examine the perceptions, opinions and interpretations of traditional healers and nurse practitioners in relation to their collaboration in primary health care in Maseru HSA.

Exploratory research according to Polit & Hungler (1993:14) “is aimed at exploring the dimensions of the phenomenon, the manner in which it is manifested, and the other factors with which it is related”. To explore, according to Woods and Catanzaro (1988:50) refers “to scrutinizing the unknown with the purpose of discovering and gaining insight into phenomena”. In utilizing the exploratory method, the researcher is more apt not to let preconceived ideas influence the research.

3.4 QUALITATIVE RESEARCH FOR TRADITIONAL HEALERS

Qualitative research has been described differently by various writers. Smith (1997:220) suggests that “qualitative research derives knowledge from subjective data about values, intuition, psychological and social forces and traditions”. He further notes that: “the outcome of qualitative research is the identification of patterns which may lead to development of theories to expand nursing knowledge” (Smith 1997:220). Brink (1991:14) on the other hand observes that “qualitative research is used when the research question pertains to the understanding, describing or interpreting of a phenomena”. Thus the major purpose of qualitative research is to illustrate meanings of relationships and to understand those relationships. Patton (1990:94) describes qualitative methods as “ways of finding out what

people do, think and feel by observing, interviewing and analysing documents". In addition, qualitative methods permit the researcher to study selected issues in depth and detail for there are no predetermined responses which can cause constraints (Patton 1990:94). The assumption is that, with this method, a lot of information can be solicited from the subjects because the questions are open-ended and allow for a lot of information to be given.

In this study, the intention was to describe traditional healers' attitudes towards collaboration with modern practitioners as well as finding out the reasons why traditional healers are utilized by people in Maseru HSA. This approach to the study was appropriate in Lesotho because it revealed the values, traditions and customs which the traditional healers take into account during the healing process. It is the incorporation of these traditions and values which makes traditional healing a popular system.

3.5 DEVELOPMENT OF THE INTERVIEW SCHEDULE FOR TRADITIONAL HEALERS

The interview schedule for traditional healers was first developed in English and sent to the promoter and co-promoter (see annexure A for the revised interview schedule). Their comments and suggestions were incorporated into the revised interview schedule. The Department of Statistics and the computer services at the University of South Africa (UNISA) were also consulted and their comments were included in the interview schedule. This interview schedule was translated into Sesotho, which is the local language (see annexure B). This had to be done because the researcher assumed that some traditional healers could not understand English. A previous teacher in the School of Nursing was requested to assist with the translation. A discussion was held on the translation and a

compromise agreement was reached particularly because the difference in semantics was little. It was agreed to leave the translation as it was.

3.5.1 Format of the interview schedule for traditional healers

Except for demographic and biographical information, most of the questions in the schedule were open-ended in order to solicit as much information from the traditional healers as possible. The schedule was divided into three sections. Section One (1) was on biographical and demographical data. This was important for classification of information according to age, level of experience in healing, educational background and area of residence. Section Two (2) was based on the healing process. The purpose of this section was to find out what the practices of traditional healers are, and if these practices would form a barrier or promote cooperation between traditional healers and nurse practitioners. Section Three (3) concentrated on how the traditional healers felt about cooperation with nurse practitioners in primary health care in Maseru HSA.

3.5.2 Pre-testing of the interview schedule

Polit & Hungler (1993:443) describe pre-testing as “the collection of data before the experimental interventions; sometimes referred to as baseline data or the trial administration of a newly developed instrument to identify flaws or assess time requirement”.

Four traditional healers were identified and they agreed to participate in interviews used for pre-testing the instrument. In this study, pre-testing was done to examine the clarity of questions, test for reliability and validity, to assess if the language used was simple enough to

be understood by the respondents and to find out if the responses would be in line with the objectives of the study.

3.5.3. Validity of the interview schedule

Polit & Hungler (1993:445) define validity as “the degree to which an instrument measures what it is intended to measure”. Burns and Grove (1997:555) also note that “validity and reliability relate to the sources from which data are collected”. They suggest that primary sources are eyewitnesses and their material is likely to be more valid and reliable. The researcher therefore interviewed primary sources. Where clarity was lacking, a question was repeated and responses were confirmed through observations to increase reliability and validity. The researcher checked the interview schedule against the objectives to make sure that they correlated. The interview schedule was then reviewed with the researcher’s promoter and the statistician from UNISA to identify any areas of bias and ambiguity. After being scrutinized, these areas were modified by the researcher

3.5.4 Content validity

Content validity was not measured through repeated testing of the instrument. Instead, the researcher ensured content validity through:

- developing questions relevant to the specific areas such as PHC activities.
- evaluation of the questionnaire by a colleague.
- pre-testing of the questionnaire to ensure that it related to the objectives.

3.5.5 Credibility

Woods and Catanzaro (1988:453), in discussing validity refer to credibility of data, and suggest that credibility can be increased by ensuring that the researcher spends enough time in the research setting to understand the context in which observations were made". They further note that "one way to establish credibility is by informant checking". During the interviews, the researcher reflected back on the informants' responses to make sure that there were no errors in the recorded information especially since the researcher did not use a tape recorder. The research was conducted between May 1998 and January 1999 which was during the height of political instability in Lesotho; this threatened the safety of the people, including the researcher particularly in travelling. The other issue which was of concern was that political instability causes lack of trust and suspicions amongst the people. However, precautionary measures on safety were taken even though no threats were encountered. The researcher spent about ninety (90) minutes with each informant which was essential for drawing credible information and conclusions. Credibility was further ensured by triangulation with different sources such as literature, participants of the study, data collection methods by some structured interviews and observations.

3.5.6 Transferability

Lincoln and Guba (1985) in Woods & Catanzaro (1988:453) suggest that during data collection, "the description must be inclusive enough to be able to transfer the findings to another social situation". After thirty (30) traditional healers were interviewed, the researcher observed that there was no more new information being obtained from the informants.

Therefore, the researcher assumed that the saturation point was reached, and that she would be able to make conclusions which could be transferred to another similar setting in Lesotho.

3.5.7 Dependability

Lincoln & Guba (1985:324) note that “dependability involves appropriateness of inquiry decisions and methodological changes -... inquirer bias should be reviewed and the extent to which decisions about the conduct of the inquiry may have been influenced by practical matters such as instability. Even though the country was in a state of “political chaos”, this did not change the manner in which the interviews were conducted, the only issue was that the researcher had to be careful about safety, considering the increase in the level of insecurity in the country. An independent coder was used to analyse the data.

3.5.8 Confirmability

Confirmability is a criterion for evaluating data quality with qualitative data, referring to the objectivity or neutrality of data. Polit and Hungler (1993:433).

Consensus was reached between the researcher and independent coder, a semi-structured phenomenological interview was used and literature control was used as triangulation to ensure confirmability.

3.5.9 Reliability

Reliability and validity of data according to Patton (1990:11) “depend to a great extent on the

methodological skills, sensitivity and integrity of the researcher". In other words, the researcher's experience goes a long way in controlling validity and reliability.

Reliability is "the degree of consistency and dependability with which an instrument measures the attribute it is designed to measure" (Polit & Hungler 1993:445). During the interview, the researcher participated with interest and showed empathy when the respondents told stories about the initiation and pre-initiation period when they referred to their illnesses. Some of the traditional healers had painful experiences and it was only proper to show empathy.

3.5.10 Ethical measures

Commons and Baldwin (1997:1) view ethics as "distinct from values", and observe that it can "be defined as an integrated body of principles that are coherent and well developed." During any research, ethical principles have to be observed in order to protect the client's rights against abuse by the researcher. These ethical principles include:

Autonomy. Smith (1997:239) notes that "autonomy is the ability of people to choose freely for themselves and direct their own lives". He further suggests that "it is essential to respect people's voluntary choices in the decision to participate. In other words, the participation of respondents in research must be a voluntary agreement".

Traditional healers who participated in the study were given a thorough explanation of the purpose of the research and confidentiality. They were informed that their participation was voluntary and if at any time they felt like withdrawing from the study, this was acceptable.

Confidentiality was ensured by telling them that their names would not be disclosed and would not appear anywhere in the study. This was done before the actual interviews were conducted by the researcher. The information was given to enable the traditional healers to make informed choices on whether to participate or not. Confidentiality and anonymity were therefore observed.

In addressing *Freedom from exploitation*, Polit & Hungler (1993:356) suggest that “the research studies must not expose the participants to situations for which they are not prepared, or put them in any disadvantage”. The traditional healers who participated in the study were assured that the information obtained from the study would not be used against them. Instead, the information would be a tool used to improve the health of people. The traditional healers were also informed that the researcher intended to make recommendations at the end of the study on how traditional healers could be given support in their healing activities.

3.5.11 Target population

Traditional healers in the Maseru Health Service Area were the target population. Traditional healers who were available and were willing to participate in the study were approached through the assistance of nurses who work in the clinics. Table 3.1 below indicates the sampling of the traditional healers.

Table 3.1 Sampling of traditional healers

Clinic	No. of healers	Selected by
Mabote	10	Clinic nurse
Bethany	9	Clinic nurse
Thaba-Bosiu	1	Clinic nurse
Mafube	1	Clinic nurse
Mahlompho	1	Clinic nurse
Likotsi	2	Clinic nurse
St Leo	2	the researcher
Herbalist Council	4	Secretary

This made a total of thirty (30) traditional healers who were interviewed.

3.5.12 Sampling method

Sampling is choosing the number of subjects who participate in the study. Polit & Hungler (1993:174) describe sampling as “a process of selecting a portion of the population to represent the entire population in the study”. The purpose of selecting a sample in this study was to reduce the expenses and the length of time that would be required to study the entire population. Convenience sampling was selected as the most appropriate method for this study as it saves money, time and effort (Patton 1990:183). It was also appropriate as the study was done at a time when there was a lot of political upheaval in the country. More importantly, it

was difficult to identify traditional healers because registration is not systematic even for those who are registered. Convenience sampling is a method which entails using an available population. However, Patton (1993:183) further notes that “it is a method that has the lowest credibility”. Polit & Hungler (1993:177) also suggest that “convenience sampling is the weakest form of sampling and therefore caution has to be exercised in interpreting the results”. The data in this study was interpreted bearing in mind this caveat.

The statistician in the Ministry of Planning was consulted for advice regarding sampling. The statistician and the researcher both agreed on convenience sampling because it was difficult to determine how many traditional healers were available in this HSA. The purpose of the study was explained to the statistician and he was given clarification on how the researcher planned to interpret the results. The results of the study are interpreted based on Maseru HSA findings. Other health service areas, especially those in the hard to reach areas, would need further studies done to enable the results to be generalised throughout the country.

3.5.13 Gaining access to traditional healers

Letters requesting permission to conduct the study and for soliciting support in various ways were written. These letters were addressed to the following offices:

- **Director Primary Health Care.**

This office was selected because it deals directly with issues affecting the communities and nurses in the clinics in the implementation of PHC activities (see annexure C).

- **Chairman Lesotho Universal Medicinemen and Herbalist Council.** The request was essential for gaining access to the registered traditional healers (see annexure D).
- **Chairman of the research committee.** The purpose was to obtain clearance from the committee for the study to go ahead (see annexure E).
- **Nurse practitioners in the clinics.** The letter requested nurse practitioners who work in the clinics to assist the researcher by making arrangements to meet the traditional healers who would be willing to participate in the study (see annexure F). The researcher made appointments with nurse practitioners who in turn contacted the traditional healers on behalf of the researcher. On the agreed date, the researcher travelled to the particular clinic where the traditional healers who agreed to participate were met.

3.5.14 Data collection from traditional healers

Semi-structured interviews were selected as a method of collecting data. Sapsford Abbott (1992:10) notes that “asking questions is part of every day life. During the interview, the researcher says very little and concentrates on eliciting ideas from the informants in the informant’s own words”. Patton (1990:353) in his observation notes that “a good interview lays open thoughts, feelings, knowledge and experience not only to the interviewer but also to the interviewee”. According to Patton’s assumption (1990:353), the process of interviewing benefits both the interviewer and the interviewee, by leaving both with knowledge of things about themselves which they did not know or at least were not aware of before the interview. This knowledge can be expected to induce change in the attitude of those interviewed. Polit and Hungler (1993:205) suggest that interviews have the following advantages:

- the researcher can have confidence in the data collected by her/himself
- the response rate tends to be high in face to face interviews
- it is less prone to misinterpretation
- additional information can be obtained through observation.

These advantages coupled with the type of study made the interview an appropriate method for collecting data from traditional healers. No tape recorder was used. Some interviews were conducted at the homes of the traditional healers while others were conducted at the clinics and others were conducted at the offices of the Lesotho Medicine Men and Herbalist's Council. The analysis of these results will be given in chapter 4 while analysis of data from nurse practitioners will be given in chapter 5.

3.5.15 Response rate

Only one traditional healer was unwilling to be interviewed by the researcher. Several attempts were made to make an appointment with her but all were in vain. Each time the researcher came to her house, she suggested she was too busy; in fact she was one of those traditional healers observed to have many clients by the researcher. One time, she agreed to meet the researcher on Sunday afternoon but when the researcher arrived, she suggested that she had no time.

3.6 ANALYSIS OF QUALITATIVE DATA

The contents of the interview were read through carefully and thoughts or ideas that were extracted were written down. This was done with all the transcribed interviews. A list of all

the topics were made and similar topics combined. This was also done by the independent coder and consensus was reached about the identified topics, categories and sub-categories. This process was done repeatedly. The literature reviewed was used to control and verify the results.

3.7 RESULTS OF THE PRE-TEST FOR TRADITIONAL HEALERS

Four traditional healers were interviewed, three females and one male; one herbalist and three sangomas. Their ages varied between fifty (50) and fifty-nine (59) years. Their work experience ranged between three (3) and twenty-one (21) years. These traditional healers were not included in the final interviews.

3.7.1 Support systems

One of the objectives in the study was to determine whether there were any support systems between traditional healers and nurse practitioners.

In this study, support systems related to training of traditional healers and having meetings with modern practitioners. All traditional healers who participated in the pre-test had not had any formal contact with nurse practitioners in the clinics or health facilities. This indicates that there was no support system between traditional healers and nurse practitioners.

3.7.2 Responses on why people consult traditional healers

Generally, these four traditional healers felt that the choice of a health care provider during illness depends on the belief about the cause of disease. If illness is associated with witchcraft, a traditional healer is consulted, and if illness is thought to be of a natural cause, then a modern practitioner is consulted. Other responses included failure of modern practitioners to cure certain diseases such as *sejeso* which literally means ingested poison. One traditional healer felt that traditional healers do well in keeping the marriages together, in diseases of women and in difficult labour.

3.7.3 Involvement of traditional healers in primary health care and collaboration with nurse practitioners

All four traditional healers had not been involved in primary health care activities with other health personnel, yet they felt that they had skills and knowledge from which the communities were benefiting. They felt that it was important for the Government to give them support in order to enhance their already existing skills.

Regarding collaboration with nurse practitioners, the traditional healers felt that it was important that referral of patients to each other be practiced for the good of the patients. These traditional healers observed that modern practitioners were reluctant to refer patients to traditional healers even where modern practitioners had failed to cure an individual, examples of such conditions which modern practitioners fail to cure were given as HIV/AIDS and cancer. One respondent felt that collaboration would be meaningful if traditional healers could be employed by health facilities and be paid a salary.

3.8 QUANTITATIVE RESEARCH FOR NURSE PRACTITIONERS

Polit and Hungler (1993:18) describe quantitative research as “the systematic collection of numeric information usually under conditions of considerable control, and the analysis of the information using statistical procedures”. Patton (1990:165) in his observation suggests that “quantitative methods require the use of a standardized approach, so that the experiences of the people are limited to certain predetermined responses”. According to this postulate, the advantages of quantitative research is the possibility that the responses of many subjects can be measured to a limited set of questions thus making the statistical analysis of data possible.

The purpose of this study was to explore and describe the existing relationship between traditional healers and nurse practitioners in primary health care. The study also aims at finding out from the nurse practitioners why people sometimes utilize the services of traditional healers and determining support systems between traditional healers and health services. Little is known about collaboration between traditional healers and nurse practitioners in Lesotho because little literature is available on this issue in the country. It is assumed that at the end of the study, the results will add to the literature on traditional healing in Lesotho. This approach to the study was appropriate in that specific responses would be obtained from the respondents which would enable statistical analysis.

3.8.1 Development of the questionnaire for nurse practitioners

A questionnaire for nurse practitioners to complete was developed (see annexure G). The questionnaire was given to the promoter and co-promoter. Their comments were incorporated. The questionnaire was also given to a colleague in the nursing department and a medical practitioner in the Family Health Division. This doctor was consulted for his skills

and experience in research in his department. The purpose of the many consultations was to seek clarity and appropriateness of the instruments in relation to the objectives of the study. One of the major tasks was to develop a coding system for the questionnaire. Coding was done with the assistance of the promoter and the statistician from UNISA. This coding made it easier to categorise information during analysis.

3.8.2 Format of the questionnaire for nurse practitioners

The questionnaire for nurse practitioners was divided into four (4) sections. Section One (1) was on demographical and biographical information. Section Two (2) covered primary health care activities while section Three (3) concentrated on the involvement of traditional healers in primary health care activities. Section Four (4) covered issues on support available to the traditional healers. The last two sections formed a basis for soliciting information on collaboration between traditional healers and nurse practitioners based in the health centres.

It also became important to find out which diseases are referred to traditional healers. This question was pertinent to reveal the pattern of usage of the two different health care systems.

3.8.3 Pre-testing of the questionnaire for nurse practitioners

The head of the midwifery section in the referral hospital, the head of the paediatric nursing section, the head of public health nursing section and a medical practitioner in the Disease Control Unit all participated in the pre-test. These professionals were selected because of their various experiences in their work. They were all females with experiences of over ten (10) years. The pre-testing was done after the questionnaire had been to the promoter and co-

promoter. Slight adjustments were made to the questionnaire. For example, diarrhoea was added to the question on referral because it was suggested that it is a common condition in Lesotho. The analysis of their responses is given in item 3.9. Their responses were not included in the final analysis of the study.

3.8.4 Validity

Polit & Hungler (1993:445) define validity “as the degree to which an instrument measures what it is intended to measure”. Brink (1996:168) notes that another way “to test if the instrument measures what it is supposed to measure is to compare it with another measure which is known to be valid”. She further suggests that the two types of criterion validity are predictive validity and concurrent validity. These two tests were not done because of the length of time that would be required to do the tests. However, validity of the questionnaire was ensured by consulting the promoter, co-promoter and the statistician. The many consultations allowed scrutinizing and criticizing of the questionnaire to uncover any hidden bias that could lead to the questionnaire lacking validity.

During the development of the questionnaire and the collection of data, the researcher was careful to note that the responses from the nurse practitioners would be sufficient to be able to transfer the findings to another similar setting. This is observed by Lincoln & Guba in Woods & Catanzaro (1988:453) who note that “during the collection of data, the description must be inclusive enough to be able to transfer the findings to another social situation”. The questionnaire was also given to three nurses and a medical practitioner (see pre-testing) to complete and to give comments to find out if there were concerns about clarity and ambiguity which could threaten validity of the questionnaire.

3.8.5 Reliability

Polit & Hungler (1993:445) states that reliability “is the degree of consistency and dependability with which an instrument measures the attribute it is designed to measure”.

Reliability is determined by four variables which are: the researcher, the subject studied, the instrument and research context.

Polit & Hungler (1993:245) states that three aspects of reliability which are of interest in quantitative data are stability, internal consistency and equivalence”. Stability of a measure “refers to the extent to which the same scores are obtained when the instrument is used with the same subjects twice (Polit & Hungler 1993:245)”. In this study, the instrument was pre-tested with a similar group to the respondents to test for stability

An instrument is said to have an internal consistency “when its subparts are measuring the same characteristics” (Polit & Hungler 1993:246). In this study, the instrument was reviewed with the promoter and statistician, as well as scrutinized against the objectives of the study to ensure that it correlated with the objectives. Correlation with the objectives indicated that the instrument measured the attributes under investigation.

Equivalence “is when two raters are using the instrument to measure the same phenomena” (Polit & Hungler 1993:248). Equivalence was not used to test reliability because it would be costly financially and in terms of time.

3.8.6 Ethical considerations

During any study, ethical principles become a concern in order to protect the participants and avoid abuses by the researcher. Polit & Hungler (1993:356) suggested that “research studies must not expose the participants to situations for which they are not prepared, or put them at any disadvantage”. The nurse practitioners who participated in the study were assured that the information obtained from them would not be used against them. Instead, the information would be used as a tool to improve the health of the people. The nurse participants were also informed that at the end of the study, recommendations would be made on how traditional healers could be supported in their healing activities in order to improve the health of the people.

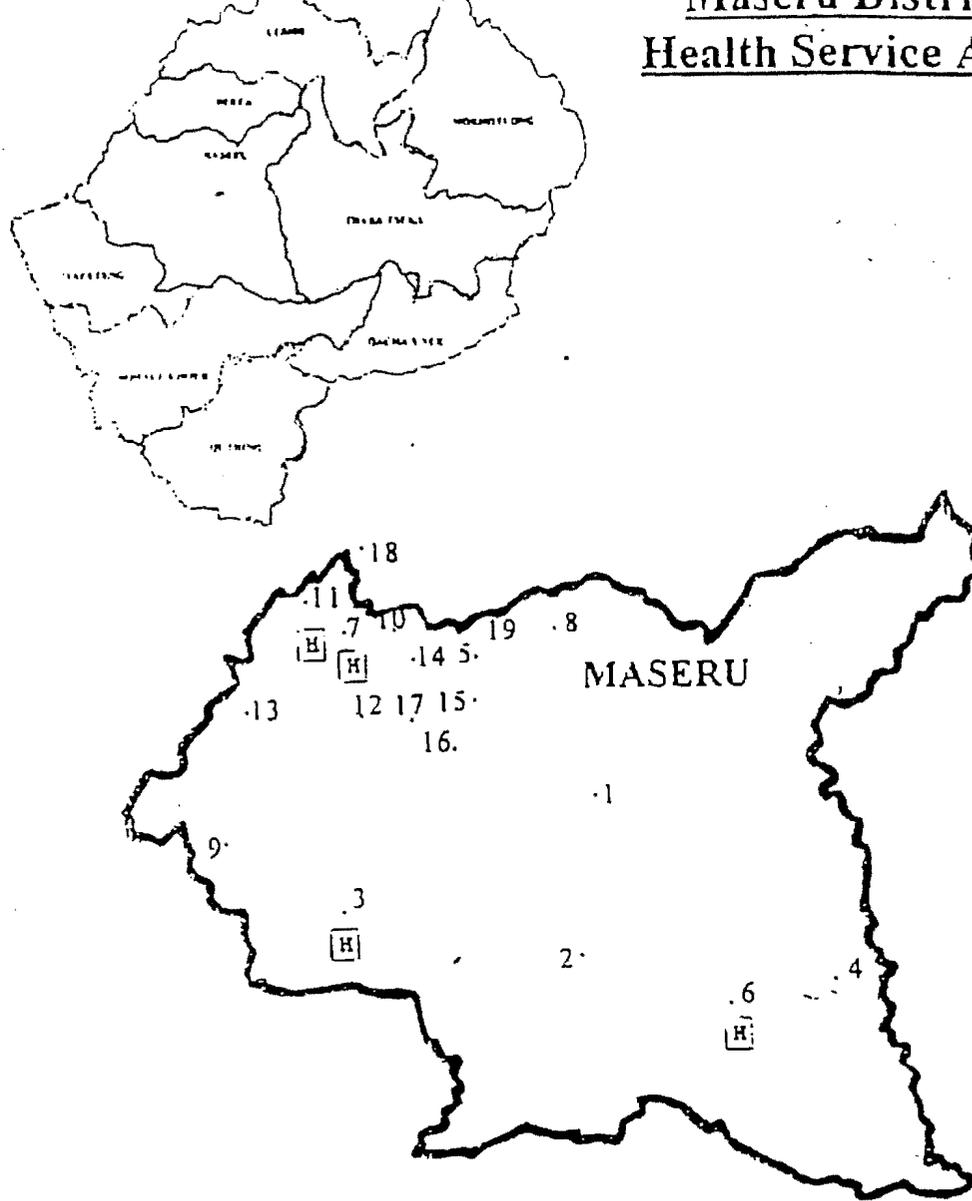
Confidentiality was another principle which was observed. Patton (1990:356) suggests that “reasonable promises on confidentiality should be kept”. Along with confidentiality was the issue of anonymity. During collection of data, no names were written down; only numbers were placed against the information collected (see annexure G). This was to ensure anonymity.

3.8.7 The target population for nurse practitioners

The target population was the nurse practitioners in the clinics around Maseru Health Service Area (HSA). The total population of nurse practitioners was thirty-nine (39) nurses from thirty (30) clinics. All the clinics had one registered nurse except for three clinics which had more than one nurse. The reason for this is that the three clinics are based in the heavily populated areas in the peri-urban area. A total of thirty (30) nurses from nineteen (19) clinics

were given the questionnaire to complete. Figure 3.1 is the Maseru District Health Service Area which indicates the location of clinics which participated in the study.

Maseru District
Health Service Area



- | | |
|------------------|---------------------------|
| 1. Nazareth | 11. Domiciliary |
| 2. Ha Tlali | 12. Qoaling |
| 3. Matsieng | 13. Likotsi |
| 4. Ha Seng | 14. Mahlomphe |
| 5. Thaba bosiu | 15. Mafube |
| 6. Semongkong HC | 16. Ha Thamae |
| 7. R.L.D.F | 17. Seventh Day adventist |
| 8. St Leo | 18. Khubatsoana |
| 9. Paki | 19. SOS |
| 10. Mabote | |

Figure 3.1 Map of Lesotho and Maseru District showing the clinics which participated in the study.

3.8.8 Criteria for selection

The selected nurses were registered nurse/midwives, enrolled nurses and nurse clinicians. The nurse clinicians are nurse/midwives who have been trained in diagnosing skills and in prescribing in primary health care. The nurse clinicians are usually based in the clinics. Three of the nurse/midwives were public health nurses whose responsibilities include supervision of the clinic nurses. One of the nurse /midwives had training in advanced midwifery. The reason why public health nurses were included in the study even though they do not work full-time in the clinics was that they supervise the clinic nurses and their ideas regarding collaboration between traditional healers and nurse practitioners would be useful.

3.8.9 Sampling method

Nurse practitioners who work in the clinics located within Maseru HSA were selected. The reason why these clinics were selected was that they could easily be accessed by road especially when the situation was tense in the country following political turmoil. The selected clinics were a combination of the clinics owned by Government (8), CHAL (4), Red Cross (1), Maseru City Council (2) and Private clinics (4) (see Table 3.2).

The reason for this selection was to avoid bias that could possibly be influenced by ownership. The researcher requested the nurse practitioners to participate in the study when they came for primary health meetings. The nurse practitioners who did not attend the meeting were approached through the assistance of the public health nurses. The questionnaires were distributed during primary health care meetings and during primary health care supervisory visits by the public health nurses. The request to the nurses to

participate in the study, the distribution of the questionnaire and the return of the questionnaire were done between June and December 1998. Unfortunately, this was a difficult period when Lesotho was experiencing political turmoil which made travelling even to the nearby areas difficult.

3.8.10 Gaining access to nurse practitioners

Letters were written to request permission to conduct the study and to solicit support in various ways. The letters were addressed to the following offices:

Director Primary Health Care.

This office was selected because it deals directly with the communities and the nurses in the clinics in the implementation of primary health care (see annexure C).

The Chairman of the Research Committee

The purpose was to obtain clearance from the committee for the study to go ahead (see annexure E).

Nurse practitioners in the clinics

The letter requested the nurse practitioners to participate in the study by completing the questionnaire. They were also requested to assist with making arrangements for the researcher to meet traditional healers who would be willing to participate in the study. (See annexure F).

3.8.11 Data collection from nurse practitioners

From the researcher's experience, mail in Lesotho takes a long time to reach the destination, at times, it does not even reach the intended place. It was for this reason that self-delivery of questionnaires became the selected method of delivery. Other advantages to this method were identified as follows:

- Questions could be asked, answered and clarified on the spot if the respondent had any.
- It was anticipated that self-delivery of questionnaires would enhance the response rate.

Some questionnaires were delivered to the clinic nurses when they came for a primary health care meeting which they hold monthly with the public health nurses who supervise them. Prior to the issuing of the questionnaire, a discussion was held with the nurses to explain to them the purpose of the study and why their participation was sought. Ten questionnaires were distributed.

Appointments were made with the nurses who did not come for the meeting. Some questionnaires were delivered by the researcher, some were distributed by the public health nurse during the supervisory visits to the clinics and health centres. Clinics where questionnaires were distributed are indicated in Table 3.2.

Table 3.2 Clinics where questionnaires were distributed

Clinic	Ownership	No. of Questionnaires
Qoaling	Government	4
Mabote	Government	2
Tlali	Government	2
Likotsi	Government	1
Matsieng	Government	2
Semonkong	Government	1
LDF	Government	1
Thaba-Bosiu	Red Cross	1
Thamae	Maseru City Council	2
Khubetsoana	Maseru City Council	2
Seventh Day Adventist	CHAL	3
SOS	Private	3
'Mahlompho	Private	1
Mafube	Private	1
St. Leo	Private	1
Lesotho Flying Doctor's Service	Government	1
Ha Paki	CHAL	1
Maqhaka	CHAL	1
Total		30

3.8.12 Return of questionnaires

Some questionnaires were collected by the researcher while others were delivered by the nurses when they came to the Ministry of Health & Social Welfare for other official activities. The public health nurses also collected some questionnaires when they went on supervisory visits. Of the thirty (30) questionnaires which were distributed, only twenty-seven (27) were received back. Three questionnaires could not be traced.

3.9 RESULTS OF THE PRE-TEST FOR NURSE PRACTITIONERS

The head of the midwifery section, the head of paediatric nursing in the referral hospital, the head of public health and the medical doctor in the Disease Control section participated in the pre-test. These professionals were selected because of their experiences in their various areas of work. They were all females and their work experience was all over ten (10) years. These health professional made significant changes in the construction of some of the sentences which lacked clarity. The medical doctor was selected for pre-testing the questionnaire because she was the head of the Disease Control Unit which works closely with communities including traditional healers.

3.9.1 Responses on collaboration with traditional healers

These four health professionals generally felt that collaboration between traditional healers and modern practitioners would be good especially if it had a component of health education. Other reasons which were mentioned that could benefit the health system and the communities included sharing of information through :

- Referral of patients between traditional healers and modern practitioners.
- Encouraging the traditional Healer's Council to identify true healers and rule out charlatans.
- Holding workshops for traditional healers and modern practitioners to disseminate health information.
- Discussing measures that can be taken against hazardous practices.

According to the public health nurse and the medical practitioner in the Disease Control Unit, some support is being accorded the traditional healers by the Ministry of Health. Some funds are already earmarked for training of traditional healers in the AIDS Programme.

3.9.2 Responses on why people consult traditional healers

The four health professionals felt that people consult traditional healers for various reasons such as :

- Basotho people believe in their traditional beliefs which include traditional healing, hence they still utilize the services of traditional healers.
- traditional healers live with the communities and they trust them because they are part of them.
- they believe that traditional healers are good in the prevention of hazards such as being struck by lightning.

The responses from both groups of practitioners indicate that very little has been done in the area of collaboration between traditional healers and modern practitioners. The responses also suggest that the people in Lesotho still value the services of traditional healers.

3.9.3 Support system

The focus of the study was to identify any support systems between traditional healers and nurse practitioners.

In this study, support related to training of traditional healers and holding meetings. According to the public health nurse and the medical practitioner in the Disease Control, some support is being accorded the traditional healers because some funds were earmarked for training of traditional healers in the AIDS programme. Holding meetings with traditional healers was not part of regular support. It was described to be an adhoc activity in some of the clinics.

3.10 ANALYSIS OF QUANTITATIVE DATA

Polit and Hungler (1993:329) note that “the purpose of data analysis is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research report”. Polit & Hungler (1993:431) further describe analysis as “a method of organizing data in such a way that research questions can be answered”. According to this postulate, a critical task for the researcher therefore was to prepare carefully for the analysis by organizing the research material in a way that the researcher could make sense of it.

The study is a combination of both quantitative and qualitative research. This suggests that some information collected from the respondents was in a narrative form (qualitative) while quantitative information was quantified in numeric form. The responses from both traditional healers and nurse practitioners were sent to the Computer Science Department at UNISA through the researcher’s promoter and the Statistics Department where analysis of information which was quantified in numeric form was done and frequency distributions determined. Analysis of close-ended questions that was in numeric form was done using the SPSS statistical analysis package for social sciences Version 6.1.2 at UNISA. This was done

with the assistance of the research support group from the Department of Computer Science. Measures of relationship were not done because most of the respondents gave similar responses. The analysis of data from both traditional healers and nurse practitioners followed the same pattern.

Data that was generated from open-ended questions was in a narrative form. The information recorded from the nurse practitioners was read through carefully and thoughts or ideas that were extracted were written down. A list of topics were made and similar topics combined. This was also done by the independent coder and consensus was reached about the identified topics, categories and sub-categories. This process was done repeatedly. A literature review was used to control and verify the results.

The main focus in the analysis and in the interpretation of data was to ensure that research questions were answered. As a result, the concentration was on the following areas:

- in what ways are traditional healers involved in primary health care at grassroots level?
- what are the support systems available to traditional healers in primary health care services?
- why do clients sometimes choose to consult traditional healers and not modern practitioners?
- what are the views of traditional healers and nurse practitioners regarding their collaboration in primary health care?

Polit & Hungler (1993:377) suggest that “analysis of research data provides the results”. The results from this research are therefore evaluated and interpreted according to the findings.

3.11 SUMMARY

This chapter has highlighted the research process that was followed in this study. It also gives information on the selection of the target population which participated in the study. The chapter outlines a brief explanation of the research design, development of the tools for collecting data and pre-testing of the tools. An outline of the procedure followed for gaining access to the participants is also given. It is concluded by giving a description of how analysis of data collected was done.

CHAPTER 4

DATA ANALYSIS FROM TRADITIONAL HEALERS

“To answer the research questions meaningfully, data must be processed and analysed in some orderly, coherent fashion so that patterns and relationships can be discerned” (Polit and Hungler 1993:41)

4.1 INTRODUCTION

Data from traditional healers was gathered through interviews as some of the traditional healers were illiterate. The open-ended questions also needed probing and observations which were done through watching and listening. During the interviews, watching and listening would also include the who, what, why, where and how of the situation.

Data analysis is presented in the same sequence as the interviews took place. Quantitative data is presented in pie charts, bar graphs and tables. Qualitative data is presented in tables giving the categories and subcategories followed by a discussion of each, also giving verbatim responses of respondents. The findings are also controlled with the literature.

4.2 FINDINGS

SECTION I BIOGRAPHICAL DATA

Item 1: Gender distribution of traditional healers

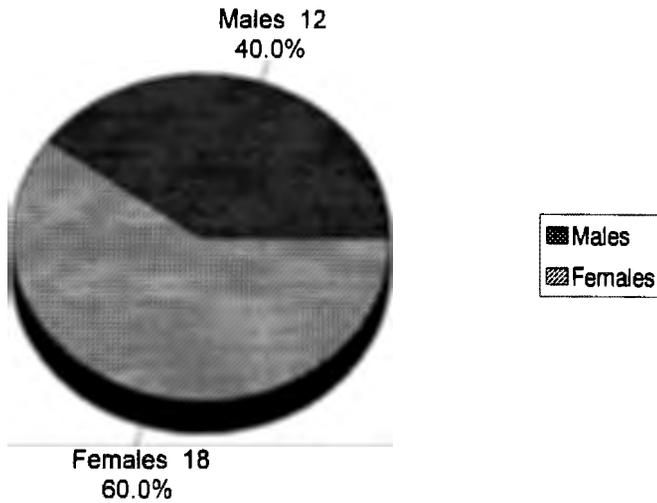


Figure 4.1 Gender distribution of traditional healers (N = 30)

Figure 4.1 shows that 60 percent of the traditional healers were females while 40 percent were males. It is not clear whether the gender difference has any significance in the healing field. Further research in Lesotho has to be done to find if at all gender plays a role in traditional healing. Edwards (1986:1273) notes that with Zulu healers, a traditional doctor (inyanga) is a male and specializes in herbal medicine, while the diviner (isangoma) is traditionally a female who operates within traditional religious supernatural context.

Item 2: Age distribution of traditional healers

Table 4.1. Age distribution of traditional healers (N = 30)

Age	Frequency
20 – 30 years	7(23.3%)
40 – 59 years	17(56.7%)
60+	6(20.0%)
Total	30(100.0%)

Table 4.1 indicates the age distribution of the interviewed traditional healers. Most (56.7%) of them were within 40-59 years old, while 23.3 percent were aged of 30 – 39 years and 20 percent were 60+ years old. The absence of anybody below 20 years does not mean that traditional healing is confined to those older than 20 years of age. According to Reynolds (1996:6), “a healer may be selected in childhood, and signs of calling in early childhood add authenticity to claims of healing ability”.

Item 3: Religious affiliation of traditional healers.

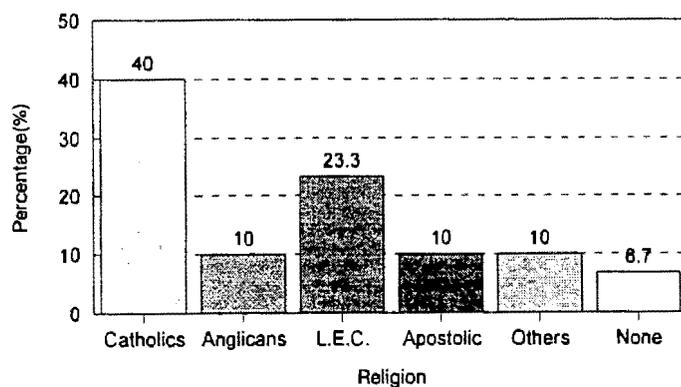


Figure 4.2. Religious affiliation of traditional healers (N = 30)

Of the interviewed traditional healers, 23.3 percent of healers belonged to Lesotho Evangelical Church (LEC). Ten percent each were Anglicans, Apostolic, or of another faith. Only 6.7 percent said they did not belong to any denomination. It is not uncommon in Lesotho to find people who do not go to any church. Most (40%) of the traditional healers belonged to the Catholic church. It is a general belief that there are more Catholics in Lesotho than other denominations, but this assumption still has to be validated through research.

Item 4: Marital Status of traditional healers

Table 4.2. Marital status of traditional healers (N = 30)

Marital status	Frequency
Married	25 (83.3%)
Widowed	2 (6.7%)
Single	1 (3.3%)
Divorced	2 (6.7%)
Total	30 (100.0%)

According to table 4.2, most (83.3%) of the respondents were married. The divorced and widowed were each 6.7 percent and only 1 (3.3%) was single. This is in agreement with the age distribution where 23 (80,0%) were between the ages of 20-59 years.

Item 5: Educational Background of traditional healers

Table 4.3 Educational background of traditional healers (N=30)

Educational background	Frequency
Never at school	8 (26.7%)
Class 1- 7	19 (63.3%)
Junior certificate	3 (10.0%)
Total	30 (100.0%)

As can be seen in table 4.3, 26.7 percent had never been to school while 63.3 percent attended at most seven forms. Only 3 (10.0%) had received a junior certificate. What accounts for the low level of education with these traditional healers is not clear. Two of the traditional healers said that they came from very religious families who also valued education, but they had to stop schooling because they were sick before they became healers. None of the interviewees had attained a Cambridge Overseas School Certificate (COSC), which is the highest academic qualification in Lesotho. Evidence suggests that people with higher professional qualifications do sometimes become traditional healers. For example, Mahlabisana (Sunday Independent 15th August 1999) a trained anthropologist, is now a traditional healer due to a calling. He explained himself in the following manner:

*I started seeing visions and at times I had strange dreams.
I think that was the time when my ancestors were bringing my
soul close to them.*

Item 6: Area of residence of traditional healers

Table 4.4. Area of residence of traditional healers (N=30)

Area of residence	Frequency
Urban	2 (6.7%)
Peri-urban	15 (50.0%)
Rural	13 (43.3%)
Total	30 (100.0%)

As table 4.4 indicates, only 2 (6.7%) of the traditional healers said they live in urban areas while 15 (50.0%) came from the peri-urban areas and 13 (43.3%) lived in the rural areas. It is not surprising that the highest percentage of the traditional healers came from peri-urban areas. The population in the peri-urban areas is growing fast due to the influx of the people who move in to town to look for jobs. According to the Bureau of Statistics (1996 census), the population of Maseru District is estimated at 385,869 out of the estimated 2 million for the entire country. The year 2000 projections and the Maseru HSA- health services area population have not yet been released. However, this gives an idea of how heavily populated the Maseru HSA is.

Item 7: The Healing Practice of traditional healers

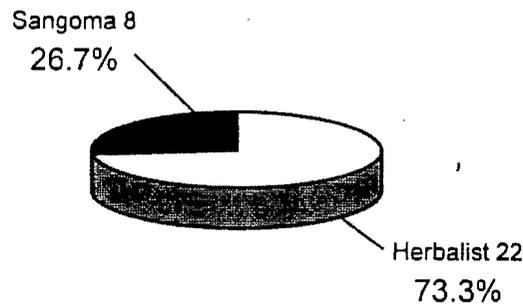


Figure 4.3. The healing practice of traditional healers (N=30)

Figure 4.3 indicates that only 8 (26.7%) of the interviewed traditional healers were herbalists while 22 (73.3%) were sangomas. Whether it is true that there are more sangomas countrywide has to be validated through further research. No spiritual healers were interviewed, because the researcher did not come across such a group. Troskie (1995:26) notes that “isangomas usually throw bones to find out what the ancestors have to say in the diagnosis of illness while herbalists will ask for the history and give herbs for treatment”.

Item 8: Length of time in the practice for traditional healers

Table 4.5 Length of time in the practice for traditional healers (N = 30)

Experience	Frequency
0 - 5 years	1 (3.3%)
6 - 10 years	9 (30.0%)
11 - 15 years	5 (16.7%)
16 - 20 years	3 (10.0%)
20 + years	12 (40.0%)
Total	30 (100.0%)

Table 4.5 depicts the traditional healers experiences in years. Only 1 (3.3%) had 5 years experience, 9 (30.0%) had worked for 10 years and 5 (16.7%) had been in practice for 11 -15 years. Those who had worked for 16-20 years were only 3 (10.0%) while 12 (40.0%) had practised for over 20 years. Given that, 96.7 percent of interviewees had more than 10 years experience, one can argue that this was an appropriate group to participate in the discussion on collaboration between traditional healers and nurse practitioners.

Item 9: Length of training of traditional healers

Table 4.6. Length of training of traditional healers (N = 30)

Length of training	Frequency
6 months	6 (20.0%)
12 months	4 (13.4%)
18 months	1 (3.3%)
24 months	18 (60.0%)
not completed	1 (3.3%)
Total	30 (100.0%)

According to table 4.6, 20.0 percent were trained for 6 months, 13.4 percent were trained for 12 months while only 1 (3.3%) was trained for 18 months and 60.0 percent were trained for 24 months. One traditional healer said he had not completed the initiation/training period because he could not afford a cow which had to be slaughtered during the final celebration. If the length of training suggests excellence, then those traditional healers who trained for 18 months and above can be assumed to be the best trained. The traditional healers who trained for only 6 months have had very little exposure but this could mean that this was a brilliant group that grasped the teachings quickly or could have lacked resources to carry training on for a prolonged period. Otherwise, it is difficult to say what it is that accounted for the vast difference in the length of training between traditional healers.

Item 10: The cost of training a traditional healer

Table 4.7 The cost of training a traditional healer (N = 30)

Cost of training	Frequency
M 50 – 500	4 (13.3%)
M 501 – 1000	1 (3.3%)
M 1000 +	5 (16.7%)
Other	20 (66.7%)
Total	30 (100.0)

As indicated in table 4.7, 4 (13.3%) traditional healers said the cost of training was about five hundred Maluti (M500), only 1 (3.3%) said the cost of training was between M500 - 1000 and 5 (16.7%) indicated that the cost was above M1000. Most (66.7%) of the traditional healers said 'other' which was interpreted by the researcher as payment with a cow. Some of these respondents could have found it difficult to convert the cost of a cow into money terms. In relative terms, the cost of training a traditional healer is cheaper than training a registered nurse in Lesotho. For example, at the National Health Training College (NHTC), the cost of training a registered nurse is M 6,200 (interview with Deputy Director Mrs Ramokoena 1999) annually, which exceeds that of training a traditional healer by far. Oyeneye (1985:68) also observes that the training costs for a traditional healer are lower than those of the teaching hospitals and the schools of nursing.

From item 11 to item 31, 12 open-ended probing questions are analysed qualitatively. All the responses to a specific question were reduced to certain patterns or categories and then interpreted. Tables are given as a guide for the quoting of data.

Item 11: Traditional beliefs that influenced traditional healers to become healers

The responses were categorised into two themes as indicated in table 4.8.

Table 4.8 Traditional beliefs that influenced traditional healers to become healers (N = 30)

Categories	Frequencies
No influence	2 (6.7%)
Existence of the ancestors	28 (93.3%)
Total	30 (100.0%)

During the interview, two of the traditional healers took time to think about the question on whether their traditional beliefs influenced them on becoming a traditional healer. Eventually, they said no as can be seen from table 4.8. The hesitation could mean that they were not sure as will be seen from their verbatim responses below. Their responses indicate that they were influenced by traditional healers, and they also mentioned ancestors' demands as a reason to train as a healer.

No influence

As indicated in table 4.8, 2 (6.7%) traditional healers said they had no influences from their own traditional beliefs. Their specific responses were as follows:

- *I came from a religious catholic family and I used to go to church every Sunday,*

my family believed in God, they would not even make reference to witches.

But, I became very ill for a long time until I was taken to the traditional healer who treated me and initiated me into being a sangoma.

- *My ambition was to get educated and get one of the prestigious jobs, but illness which could not respond to treatment took me to a traditional healer who said my ancestors wanted me to be a sangoma.*

Existence of the ancestors

The traditional healers who felt they had been influenced by their own traditional beliefs were 28 (93.3%). They indicated that they were brought up by their traditional families which valued traditional beliefs and customs amongst which were traditional healing. Some of their verbatim responses were:

- *A traditional Mosotho knows that Basotho people have their beliefs and traditions which include traditional healing. It is therefore no surprise that I am a sangoma. This is a gift which is bestowed upon me by my ancestors.*
- *I believe in Basotho customs and traditions, I also believe that our ancestors communicate with us in our dreams and sometimes through the illness which one experiences.*

Item 12: In your healing practice, do you work alone or with other people?

All respondents, (100.0%) said that they worked alone in the healing practice. The impression given is that the tradition in traditional healing is to work alone. The reasons for working alone are given in item 13 below.

Item 13: Reasons why traditional healers work alone

The categories displayed in table 4.9 were extracted from the responses given by the traditional healers on the reasons why they worked alone. Except for the group that said they never thought of group practice before (13.3%), the rest (86.7%) of the traditional healers were confident and adamant that group practice was not the best approach for traditional healing. Their verbatim responses indicate that traditional healing is guided by ancestral wishes only.

Table 4.9. Reasons why traditional healers work alone (N = 30)

Categories of responses	Frequencies
Gift from the ancestors	13 (43.3%)
Expertise and experience	8 (26.7%)
Avoid conflict	5 (16.7%)
Never thought of a group	4 (13.3%)
Total	30 (100.0%)

Gift from the ancestors

According to table 4.9, 13 (43.3%) traditional healers indicated that traditional healing is a gift from their ancestors who also value confidentiality therefore, group practice would not be easy.

Their verbatim responses included the following:

- *traditional healing is a talent that one gets from one's ancestors. It is not a choice that an individual makes on her/his own. The ancestors make the decision on who should be given this talent. Therefore, it cannot be shared hence working alone is essential*
- *What I do is done according to the instructions from my ancestors, if they want me to practice in a group, they will tell me. I do not want to work with other people lest I offend them. They can actually withdraw their support if they are not happy with me or even make me sick as a sign of unhappiness.*

Expertise and experience

Table 4.9 indicates that 8 (26.7%) traditional healers said that working as a group would necessitate knowing the experiences and knowledge of the group members to avoid those who are “quacks”. Their responses included the following:

- *Some traditional healers claim knowledge which they do not have. I want to keep my good name by working alone. Those who make false claims can spoil my name.*

I would have to be convinced that a traditional healer has enough experience and expertise before I can work with them but I do not think that at this stage it is essential to work with another person.

Avoid conflict

As indicated in table 4.9, 5 (16.7%) traditional healers indicated that they do not work as a group because people usually have different views and the lack of agreement on certain issues can bring animosity instead of the expected cooperation. Their verbatim responses were as follows:

- *Working with people is not an easy task especially where there is little knowledge and issues that affect profit, a lot of cheating can take place thus causing unnecessary conflict.*
- *Working with another person is a demanding task especially if the other partner is not a hard worker or is not an expert in the job to be done, disagreement is bound to arise thus being the beginning of conflict. I want to be responsible for my healing activities.*

Never thought of it before

According to table 4.9, 4 (13.3%) traditional healers indicated that they never thought of working as a group before, hence they work on their own. Some of their responses were as follows:

- *I never thought of working as a group, nobody has suggested group practice before.*

The responses given in this question indicate that the link between the ancestors and the healers is very strong. It appears that it is the ancestors who actually determine the healing activities. Troskie (1995:20) also notes that the importance of unity between the living and the no longer living is seen in the continuing effective involvement of the ancestors.

Item 14: When a client consults you, do you treat him alone or with the family?

In this question, all (30) traditional healers who were interviewed said that they treat patients as individuals unless the instruction is given to treat the entire family. They also revealed that treating a family involves extra costs therefore, only when the family wishes it the treatment covers the family. Holistic approach to treatment suggests involving the family in the treatment of the patient. They also noted that when necessary, the healer usually advises the individual to have the family incorporated into the treatment especially where illness is associated with witchcraft or if some preventive measures have to be taken against hazards, such as being struck by lightning. All traditional healers added that, they involve the family by explaining to them how medicine should be taken to ensure that the family adheres to precautionary measures. Brandt (1984:19) supports family involvement in the treatment when he notes that: "holistic care of patients necessitates involving their families in the care". The reason for saying that the family was not treated indicates that the question was misinterpreted by the respondents. This became clear from the answers given when probed, when all traditional healers said that they believe in the importance of holistic care.

Item 15: Advice given to clients who do not respond to treatment

The responses from this question were categorised as indicated in the table below.

Table 4.10 Advice given to clients who do not respond to treatment (N = 30)

Categories	Frequencies
Go to traditional healers	1 (3.3%)
Nobody came back	3 (10.0%)
Refer to the clinic	26 (86.7%)
Total	30 (100.0%)

Go to the traditional healer

As indicated in table 4.10, 1 (3.3%) traditional healer said she advises such patients to consult the traditional healer who trained her. Her verbatim response was:

- *I refer such patients to my trainer who is also my professional guardian on this earth. She knows what she is doing, I respect her because she has also contributed to building me into what I am today. Besides my ancestors, she is also my support system.*

Nobody came back

The three (10.0%) traditional healers who said that the patients did not come back, could have implied that the patients were seen only once because they were either cured or sought other

treatment. It was therefore not necessary to give the patients advice, because they did not know whether patients responded to treatment or not.

Refer to the clinic

Twenty-six (86.7%) said that they usually refer such patients to the nearest clinic or hospital especially those with long debilitating diseases or pregnant women. The verbatim response was:

- *I refer those who have been ill for a long time and I feel they need nursing care, sometimes I refer those who need treatment through an operation or injection to the clinic or hospital.*

This popular response is encouraging because it shows that traditional healers are aware that modern practice has gained superiority in certain areas. This is supported by Walker (1989:191-192) who said that in a study in Soweto, thirty-four patients who consulted traditional healers and needed appendicectomy ended with referral to the hospital. This suggests that some traditional healers give appropriate advice to clients with complex problems. What needs to be done is to strengthen their skills and support.

Item 16: Reasons why people consult traditional healers

The responses to item 16 were in two parts. The first part was on reasons why people consult traditional healers and the second part was on why people consult modern practitioners.

All thirty (30) respondents answered the question. The categories as displayed in table 4.11 below were extracted from the responses.

Table 4.11 Reasons why people consult traditional healers (N = 30)

Categories	Frequencies
Social problems	2 (6.7%)
Preventive measures	2 (6.7%)
When bewitched	13 (43.3%())
Failure of modern practice	8 (26.7%)
Good at diagnosing cause of disease	5 (16.6%)
Total	30 (100.0%)

The traditional healers who indicated that people consult them for social problems and preventive measures were confident that they solved the problems. They asked the researcher to refer anybody with marital or work problems to them as they are able to handle such cases.

Social problems

Social problems were mentioned by only 2 (6.7%) respondents. These included problems related to marriage, and finances, for example, seeking promotion at work or looking for a job. Their verbatim responses included:

- *Some traditional healers do well in keeping the families together and ensuring that a man does not see other women.*
- *people go to traditional healers when seeking a promotion or when they are*

looking for employment.

This category is confirmed by Pearce (1989:921) who notes that “diviners are sought for supernatural interventions on problems related to stress and problematic relations”. Vontress (1991:243) also notes that people go to traditional healers for getting promotion at work, passing examinations, winning a soccer game and persuading the spouse to be faithful.

Preventive measures

“Preventative measures” included protection of property from theft and protection of people against ill-omen such as being struck by lightning which is believed to be man made. Traditional healers also claimed to be knowledgeable in the prevention of hail storms which usually destroys crops. Only two (6.7%) traditional healers mentioned these preventive measures. Some of their specific responses included the following:

- *people come to us when they want to protect their animals against theft or when those animals have been stolen and need to be recovered.*
- *in summer especially, some people use lightning to kill others and hail storm tends to destroy crops. Some traditional healers have the capability to protect families against lightning and protect crops from hail storm.*

This belief is also supported by van Nierkerk in Troskie (1995:79) who indicates that:

when students go to the university, they have to visit an isangoma to get medicine that will protect them in the new environment. When they get a degree, they become afraid of the jealousy of others who have not had the opportunity for this achievement and start to think of being bewitched. They once again visit an isangoma for further protection.

Maloka (1994:196) also mentions that traditional healers are consulted by Basotho men before going to the mines for protection. This suggests that the role of traditional healing in preventive medicine needs to be seriously evaluated before it can be dismissed as nothing but superstition. Mahoko (1997:61) in her thesis also mentions that cleansing and fortification of homes and persons for preventing diseases and accidents was common in the North West Province of South Africa.

When bewitched.

Most interviewees (43.3%) indicated that people consult traditional healers when they think they are bewitched. Some of the responses were :

- *people often will come to traditional healers when they are possessed by thokolosi and think they have been bewitched.*

- *when they meet misfortunes or become ill from any disease which is associated with witchcraft for example epilepsy. The jerky movements in epilepsy are a result of thokolosi suffocating a person.*

Witchcraft in the African context is complex and difficult to understand by people not involved. However, Skjonsberg (1989:166-8) refers to a witch as someone who does things with charms with the intention to harm others. According to Skjonsberg (1989 : 166 – 8) “witchcraft is personification of evil and causes suffering in the world which cannot be explained. It is a source of power not only to active practitioners, but also to those who claim to be able to neutralize the witch single handedly”. Elmslie in Smit (1987:16) also notes that:

*the belief in witchcraft is the most powerful of all forces at work among the tribes
...It is a slavery from which there has been no release. Man lives in fear. If he is
sick, it is not a question of how he may be cured, but of who has bewitched him.*

Failure of modern practice

Eight (26.7%) of the interviewed traditional healers indicated in this category that people consult traditional healers because of failure of modern practice to cure certain diseases. Their verbatim responses were as followed:

- *Hospitals are full of very sick people who often die in hospitals or are told by the doctors that they are discharged because nothing can be done. This is failure on the part of modern practitioners.*
- *patients sometimes go from one medical doctor to another without being told the cause of the disease and without recovering from the illness.*

Mzimakwe's (1996:313) observation also supports the above claim when, she observes that "the rising incidence of disease of unknown etiology and incurable diseases such as AIDS and cancer has led to traditional healers seeing more clients who are disappointed with western medicine".

Good at diagnosing cause of the disease

As table 4.11 indicates, 5 (16.6%) traditional healers indicated that people go to traditional healers when sick because the traditional healers will tell the client the root cause of the disease.

Some of the responses included the following:

- *modern practitioners will never tell you what is wrong with you, instead, he will ask you what is wrong with you or ask you where the pain is. Sometimes as you talk to him, he is not listening instead he is writing.*
- *a traditional healer will tell you that you have headache because there is no peace in your family or your foot is aching because you walked over medicine that was meant to harm you by your enemy or somebody who was angry with you because your chicken ate his/her vegetables in their garden.*

Mahoko (1997:82) in her study also observed that traditional healers tell the client the cause of the problem through diagnostic methods. According to Mahoko (1997:82), the client does not tell the doctor about the problem. Fako in Mahoko (1997:20) also notes that people consult indigenous healers to discover the actual cause of illness as well as to obtain a meaningful explanation for their health problem.

Some respondents in the above categories mentioned more than one reason for seeing a healer. In some of the responses, they mentioned diseases for which traditional healers are seen as better consultants. Such diseases included *litoromo*, *sejeso*, STDs and high blood pressure. One of the respondents actually mentioned that he had a nurse who was consulting him for high blood pressure because modern medicine was not making any progress, but she felt much better with the traditional medicine she received from him.

Item 16: Reasons why modern practitioners are consulted

Table 4.12 Reasons why modern practitioners are consulted (N = 30)

Categories	Respondents
Weak blood, injuries and broken bones	7 (23.3%)
Operations, injections and tablets	7 (23.3%)
Diabetes, high blood and eyes	3 (10.0%)
Failure of traditional healing	3 (10.0%)
Social status and trust	7 (23.3%)
Sick leave	2 (7.0%)
Not sure	1 (3.3%)
Total	30 (100.0%)

The responses on why people consult modern practitioners were categorised as indicated in table 4.12.

Weak blood, injuries and broken bones

At least 7 (23.3%) traditional healers indicated that people consult modern practitioners for diseases related to weak blood, when they have broken bones and for other injuries. It is encouraging to note that traditional healers observe that modern practitioners have done well in some areas and also to note that they are aware that an individual's blood may be weak at some stage thus needing medical attention. Sechaba Consultants in Moji and Rogas (1993:19) also note that people go to modern practitioners for diseases such as asthma and weak blood.

Use of operations, tablets and injections

Seven (23.3%) of the respondents felt that people go to modern practitioners when they feel they need treatment that will be given through an operation, injection or tablets. This response amazingly, presupposes that an individual who is sick can determine the type of treatment he/she needs whereas it is usually the medical officer who makes the decision. One traditional healer said:

- *sometimes people believe in the effectiveness of operations, injections and tablets depending on the problem she has.*

Diabetes, high blood pressure and eye problems

Only three (10%) of the traditional healers were of the opinion that people consult modern practitioners for diabetes, high blood pressure and problems of the eyes. An awareness needs to be raised amongst traditional healers on diabetes and high blood pressure, especially because

these two conditions are becoming a problem in Lesotho. For example, Queen Elizabeth II Hospital (Q.E.II) records indicate that in June 1999, 362 patients with diabetes and 330 hypertensive patients were seen at the Polyclinic. These figures exclude the patients seen in the filter clinics and other clinics around the referral hospital.

One traditional healer who said people also consult modern practitioners for diseases of the eyes said:

- *People go to see the eye doctor when their eyes cannot see anymore or a foreign object has got into the eye or because damage has occurred following trauma, then the doctor gives him/her "leihlo la 'mabole".*

In some traumatic cases an enucleation of the eye may be done and a prosthesis fitted to the affected eye. A prosthesis in the local language is referred to as 'leihlo la 'mabole", literally, it means an eye made of marble.

Failure of traditional healing

Table 4.12 indicates that three (10%) of the traditional healers said that modern practitioners are consulted when traditional healing has failed. It is encouraging to note that some traditional healers are aware that traditional healing has its weaknesses. This is surprising because in item eighteen (page 142), twenty-eight (93.3%) traditional healers indicated that they consult modern practitioners when sick because, among other things, some traditional healers are not reliable. One would have expected more traditional healers to mention failure of traditional healing.

Social status and trust

Of the respondents, seven (23.3%) of traditional healers indicated that modern practitioners are consulted because they are ranked higher than traditional healers in the society. Their medicine is classified as scientific therefore, anybody utilizing their service is viewed as understanding and modern. The verbatim response was:

- *Because they have gone to expensive schools and they wear white coats, everybody thinks they are better than everybody and they think they know everything, yet they do not know our art of healing.*

Ferreira (1987 : 141) notes that if individuals identify with western values, norms and standards and they view themselves as modern, they will prefer medical care that represents these values and will use only western biomedically trained-doctors.

Some traditional healers also mentioned that some people trust modern practitioners especially for those conditions which are taken to be of natural origin such as asthma. Sechaba Consultants in Moji and Rogas (1993 : 19) indicate that people consult modern practitioners for diseases such as asthma, rash and weak blood.

Sick leave

Only two traditional healers said that the working population consult modern practitioners because they can give them sick leave. Traditional healers raised concern that there is no reason why their clients are not allowed sick leave when necessary, because they believe their practice

is just as legitimate as modern medicine. In a formal work situation, a letter from a traditional healer is not accepted as an authentic document for sick leave.

Not sure

According to table 4.12 one traditional healer said:

I am not sure why modern practitioners are consulted by people, you can get a satisfactory answer if you ask them.

Item 17: Conditions for which traditional healers are consulted

About half (50%) of the traditional healers took some time to think about this question, possibly suggesting the lack of accurate information they have for diagnosis. This was confirmed by the fact that diseases were mentioned randomly. Admittedly, this may not have been an easy question for traditional healers particularly because they do not normally keep the statistics of their clients. If they do, they do not reveal the specific conditions.

Table 4.13 Conditions for which traditional healers are consulted (N = 30)

Diseases consultation	Frequency
Aids	1 (3.3%)
Gastro-enteritis	3 (10.0%)
Epilepsy	11(36.7%)
Others	15 (50.0%)
Total	30 (100.0%)

Table 4.13 indicates the conditions for which traditional healers are mostly consulted. Only one (3.3%) traditional healer said she was consulted for AIDS. Three (10%) traditional healers indicated that they were consulted for gastro-enteritis while 11 (36.7%) traditional healers were consulted for epilepsy.

The most popular response was others with fifteen (50.0%) traditional healers. Sechaba Consultants in Moji and Rogas (1993 : 19) indicate that people consult traditional healers for conditions such as “seizures by spirits”. This corresponds well with item sixteen where a list of various reasons were given for consulting traditional healers. “Others” were specified as “sejeso”, “litoromo”, high blood pressure, STDs, and social problems such as being liked by the boss at work.

Item 18: Practitioner consulted by traditional healers when sick

Table 4.14 Practitioner consulted by traditional healers when sick (N = 30)

Practitioner consulted	Number
Modern practitioner	28 (93.3%)
Traditional healer	2 (6.7%)
Total	30 (100.0%)

Only two (6.7%) traditional healers said they begin with self-treatment, on the instructions of the ancestors, when sick. Ferreira (1987 : 140) notes that indigenous practices indicate that people prefer to treat their illnesses themselves, especially in the early stages. Only when they have exhausted their knowledge of indigenous cures and the condition has not responded to treatment

will they consult medical doctors.

The remaining of the traditional healers (93.3%) indicated that they usually consult modern practitioners when they are sick. This response is revealing, as it shows that as much as traditional healers believe in traditional healing, they do not trust the work done by other traditional healers when it concerns them. However, the next item will give reasons why traditional healers choose to consult modern practitioners when they are sick.

Item 19: Reasons for choice of practitioner by traditional healers

The responses were categorized as indicated in table 4.15 below.

Table 4.15 Reasons for choice of practitioner by traditional healers (N = 30)

Categories of responses	Number
Some traditional healers are quacks	10 (33.4%)
Modern practitioners different approach	4 (13.3%)
I tried but they failed	4 (13.3%)
For natural cause of disease	12 (40.0%)
Total	30 (100%)

Some traditional healers are quacks

As indicated in table 4.15, ten (33.4%) traditional healers said they consult modern practitioners because some traditional healers are not knowledgeable. Some of their specific responses were:

- *It is difficult to differentiate between a true healer and one who is cheating.*
- *Some traditional healers are not good in healing and they can actually give poison. How some of them learned the art of healing and from whom is a question mark.*

Herbst and Britz (1987 : 33) note that the indigenous healers' profession also has its charlatans who practise without the necessary background training.

Modern practitioners use a different approach

In this category, four (13.3%) traditional healers said that they consult modern practitioners because they use an alternative approach to curing people. The verbatim responses were:

- *Modern practitioners can manage weak blood and I often feel strong after taking their medicine for weak blood.*
- *Their injections are sometimes strong and are good in the cure of certain diseases.*

I tried but I failed

As shown in table 4.15, four (13.3%) traditional healers said they consulted traditional healers previously but were not successful. Some of their responses were as follows:

- *I have tried traditional healers but I have failed, some of them believe that members of my family are too strong and heavy for them because I know more than they do, therefore, they fail to treat us when we are sick.*
- *I have been to some of the traditional healers, I know how they work and they have failed*

to convince me that they can cure me.

For natural causes of disease

Most of the respondents (40.0%) said that they consult modern practitioners because their problems have always been of natural origin. These traditional healers believe that traditional healers can handle health problems caused by another man better, for example, when they are bewitched. Some verbatim responses were:

- *The choice of a health practitioner depends on the cause of the problem, most of the health problems I experienced were of natural cause and could be treated by injections.*
- *There is a saying in sesotho which says “ngaka ha e iphekole” which means that a traditional healer does not cure himself. I therefore prefer modern practitioner when I am sick, unless if I am bewitched.*

Item 20: How a person is trained to be a healer

Responses were categorised as indicated in table 4.16

Table 4.16 How a person is trained to be a healer (N = 30)

Categories of responses	Respondents
Do not train	9 (30.0%)
Trainee gets sick and has a vision	21 (70.0%)
Total	30 (100.0%)

One of the traditional healers was very confident in responding to all the questions. It was at this stage that he offered to show the researcher his consulting room. The room was very clean, all medicines were in labelled containers either as leaves, roots or powder. There was a candle which he lights before saying a prayer each time a client is examined and treated. The idea of labelling medications is one that will need reinforcement if cooperation is to succeed.

Other traditional healers who were interviewed in their homes had roots, leaves and barks of trees, but these were not in containers and were not labelled.

Table 4.16 shows that nine (30.0%) traditional healers said they do not train anybody. Of these respondents, one was a sangoma who did not complete training because he could not afford a cow to be slaughtered during the final celebration. The other eight respondents were herbalists who indicated that their children and other close members of their families were not interested in healing. They were not keen to train people from outside their families because this would be as good as to giving out a family talent.

Vision and illness

Vision and illness are grouped together because they occur more or less simultaneously. Most of the respondents (70.0%) said that their clients first become sick and will not respond to treatment. The clients then have a vision or a dream in which the ancestors show him/her where to go for initiation. This is called 'ho thoasa' in Sesotho. During the initiation, a goat is slaughtered and medicine mixed with the goat's blood is given to the initiate to drink. Part of the initiation includes wearing of beads on the head, around the wrists and ankles. The individual has

to follow the instructions of the ancestors. For example, she may have to avoid wearing shoes during training.

For a period of 6 – 18 months, the novice is taught the use of various herbs as well as the divining process because this is an important aspect of a sangoma. This process will help a sangoma to reveal the cause of disease during the healing process. In addition, five sangomas noted that they usually have to live with the trainees in their own homes during the learning process. The reason is to ensure that they abstain from sexual activity, which is a requirement.

At the end of training, a celebration is held and a cow is slaughtered. Dancing by sangomas, singing and clapping of hands takes place the whole night (hlophe). Observers can only sing and clap hands as dancing is the monopoly of the sangomas. Henderson in Mahoko (1997 : 41) notes that music and dance are also important aspects of indigenous healing among Africans because of its therapeutic effects.

After the final celebration, the graduate is expected to work alone under the guidance of the ancestors with limited support of the trainer if necessary. Troskie (1995 : 13) also notes that the trainee first starts with spells of illness which do not respond to treatment. During this period of apprenticeship, sexual intercourse is not allowed. Mahlabisana who is an anthropologist and a Mngomá (Sunday Independent 8th August 1999) described his experience: “I started seeing visions and at times I had strange dreams. I think that was the time when my ancestors were bringing my soul close to them”.

Living with a trainee in the trainers home during the trainee’s illness and the initiation period is a

sign of commitment and caring on the part of the trainer. It is a symbol of willingness to assist and support the trainee who is often sick and in distress. Montgomery (1991 : 61) verified this statement when he revealed that “commitment is evidenced by going beyond the call of duty, when an individual cares . . . commitment means doing those little extras. Being with the patient is a powerful way to communicate caring”. The observation is that, there is near universality in the training of the sangomas. This training reveals that there is close relationship with their ancestors who communicate with them to guide them on issues concerning life.

Item 21: Costs of training a traditional healer

Table 4.17 Costs of training a traditional healer(N = 30)

Costs	Respondents
M50 – 500	0
M501 – 1, 000	6 (20.0%)
M1001 and above	1 (3.3%)
iv. NA	23 (76.7%)
Total	30 (100.0%)

Table 4.17 indicates that 6 (20.0%) traditional healers said they charge a maximum of M1,000, to train trainees while only 1 (3.3%) traditional healer charged above M1,000. Of the traditional healers, most (76.7%) said payment was not applicable. This came as a surprise because in item 10, they showed that they paid for training. Asked why they do not charge for training they revealed that their ancestors have to guide them on how much they should charge an individual for training, thus their fees were not fixed. This system of practice could be a way to justify whatever fee the healer wants to present to the trainee, unless the ancestors select a charge lower

than expected.

Item 22: Cost of consultation

Table 4.18 Cost of consultation (N = 30)

Cost	Frequency
M5 – 50	27 (90.0%)
M51 – 100	1 (3.3%)
M101 – 150	0
M150 and above	2 (6.7%)
Other	0

Most of the respondents (90.0%) according to table 4.18 said that they charge between M5 and M50. This does not differ much with fees in government institutions in Lesotho where an adult pays M10 for consultation including medications, with the exception of the clinics where an adult pays M5. Only 1 (3.3%) traditional healer indicated that she charges between M51 and M100, while 2 (6.7%) said they charge above M150. Anyinam (1987 : 806) observed that “indigenous medicine might have been cheaper some decades ago but it is an overgeneralization to suggest that the cost of seeking treatment from the indigenous medical sector is very cheap in the present day Africa”.

Item 23 : Collaboration with modern practitioners

Table 4.19 Collaboration with modern practitioners (N = 30)

Responses from this item were categorised according to items in table 4.19.

Categories in collaboration	Respondents
i. No collaboration	1 (3.3%)
ii. Referral of patients	29 (96.7%)
iii. Have a corner at health facility	3 (10.0%)

No collaboration

Only 1(3.3%) traditional healer said she did not wish to collaborate with modern practitioners because her practice was completely different from that of modern practice. She would only accept collaboration if the ancestors invited her to do so. Otherwise, the healer may be alienated and lose support from ancestors.

Referral of patients

The rest of the respondents (96.7%) said that modern practitioners should learn to acknowledge their weaknesses hence the need to refer patients to traditional healers. But they also acknowledged the need for traditional healers to refer patients to modern practitioners. Of the 96.7 percent of traditional healers who advocated referral, to modern practitioners three (10.0%)

traditional healers added that modern practitioners should assign a corner at a health facility to traditional healers for practising and also to facilitate referral of patients. Some of their responses included the following:

- *Some modern practitioners do not trust us, they think we do not know what we are doing, cooperation will teach them the wonders we can do.*
- *Modern practitioners must acknowledge that they cannot deal with certain diseases, therefore they must refer patients with such diseases to us and traditional healers must do likewise.*

The above suggestions were supported by traditional healers who participated in a workshop organized by the Psychiatric Hospital in Maseru on the 3rd February 1999. The traditional healers in that workshop resolved that collaboration should cover the following areas:

- *Health facilities should assign one corner each for traditional healers where they can practise.*
- *Modern practitioners also to refer patients to traditional healers especially those who have problems related to beliefs, traditions and customs.*
- *The ministry of Health together with the Lesotho Universal Medicinemen and Herbalist Council to design a referral form for use by both.*

Designating a corner at the health facility is already being done in some areas in South Africa. For example, according to Clarke (1988 : 8), Mrs. Bhengu, who graduated as a Sangoma and works in partnership with doctors of the Valley Trust, said that “traditional healers have never

seen their simultaneous practice of traditional medicine and western-based primary health care as conflicting”. In fact, traditional healers working within the framework of Valley Trust treat their patients with traditional methods and refer them to the clinic doctors when necessary (Clarke 1988 : 8).

Item 24: Collaboration with modern practitioners regarding diarrhoea, AIDS and Tuberculosis

Table 4.20 Collaboration with modern practitioners regarding diarrhoea, AIDS and Tuberculosis (N = 30)

Diseases	Methods of collaboration	Frequency
Diarrhoea	Refer dehydrated patients to hospital.	29 (96.7%)
AIDS	Cooperation can bring cure, critical patients be must referred to the hospital.	29 (96.7%)
Tuberculosis	Sejeso responds to traditional medicine. Patients be referred to traditional healers.	29 (96.7%)

Diarrhoea

As indicated in table 4.20, 29 (96.7%) traditional healers said that they wish to refer dehydrated patients to the hospital. They also suggested that in the prevention and treatment of diarrhoea, they can learn from each other. Some verbatim responses were:

- *We traditional healers are capable of preventing diarrhoea especially in children. Working with modern practitioners can facilitate learning from each other.*

- *We wish to refer those children who have lost a lot of water to modern practitioners for treatment with drip.*

AIDS

Traditional healers (96.7%) felt that AIDS is an old disease, but trust and cooperation can bring success and a cure. They were of the opinion that critical patients should be referred to the hospitals for nursing care. Some of the responses were as follows:

- *AIDS is a new disease according to modern practitioners. Some traditional healers feel it is old and they refer to it as "old syphilis". Trust and cooperation can bring cure.*
- *very sick patients with AIDS should be referred to the hospitals for nursing care, but modern practitioners must refer the newly diagnosed AIDS patients to us because some traditional healers can treat AIDS.*

Tuberculosis

Traditional healers felt that what modern practitioners diagnose as tuberculosis is *sejeso* hence it does not respond to their treatment. They suggest that modern practitioners should be encouraged to refer such patients to traditional healers. In their responses, they included:

- *hospitals keep patients with sejeso for a long time and these patients do not respond to treatment because only traditional healers can treat it.*
- *for success in the treatment of sejeso modern practitioners should be encouraged to*

refer such patients to traditional healers.

The above information reveals that there is stiff competition between tuberculosis and sejeso. Lesotho Tuberculosis Control Programme notes that Maseru HSA has the highest Tuberculosis rate at 720/100,000 population (Ntšekhe, Makakole and Corcoran 1997 : 3). With the attitude of traditional healers towards tuberculosis, the disease rate is likely to increase because they are likely to encourage the use of traditional medicine only when they are consulted. The other alternative would be to allow tuberculosis patients to use both traditional medicine and the recommended tuberculosis drugs simultaneously. But this also raises questions such as drug interaction and drug resistance. For example, Cookfair (1996 : 465) notes that drug resistance sometimes is a result of failure to take medications as prescribed and also follows when patients have taken ineffective treatment regimen. Ferreira (1987 : 141) also observes that “traditional medicine can retain legitimate function alongside modern medicine, especially if there is no threat of physical or emotional damage to the users”. This suggests that referral of tuberculosis patients to traditional healers needs to be carefully studied and evaluated.

Item 25 : Diseases which traditional healers can treat successfully

Table 4.21 Diseases which traditional healers can treat successfully

Diseases	Frequency
Gastro-enteritis	6 (20.0%)
Tuberculosis	13 (43.3%)
AIDS	2 (6.7%)
Epilepsy	10 (33.3%)
Others	20 (66.7%)

In table 4.21 some traditional healers mentioned more than one disease which they can treat.

Gastro-enteritis

Of the respondents, 6 (20.0%) traditional healers said they can treat diarrhoea successfully.

Tuberculosis

Tuberculosis was the most popular response with 13 (43.3%) respondents indicating that they can cure this successfully. This coincides with the responses in item 24 where traditional healers suggested that hospitalized tuberculosis patients do not respond to hospital treatment, therefore such patients should be referred to them.

AIDS

Only 2 (6.7%) traditional healers said they could treat patients with AIDS successfully

Epilepsy

As table 4.21 indicates, 10 (33.3%) traditional healers said they could treat patients with epilepsy successfully. This is not surprising because epilepsy, according to Sechaba Consultants in Moji and Rogas (1993 : 19) is defined popularly as “Seizure by spirits” and people consult traditional healers for this condition.

Others conditions treated by traditional healers

Table 4.22 Other conditions treated by traditional healers

Diseases	Respondents
“Sejeso”	11 (36.7%)
“Litoromo” (Swollen feet)	10 (33.3%)
Mental illness	10 (33.3%)
STDs	7 (23.3%)
Diseases of women	7 (23.3%)

Table 4.22 indicated that *sejeso* which is usually linked to tuberculosis was the most easily

treated ailment, with eleven traditional healers saying they can treat it successfully. “Litoromo” and mental health were mentioned by ten traditional healers each while STDs and diseases of women were each mentioned by seven traditional healers.

Item 26: Cooperation with modern practitioners?

The responses were categorised according to table 4.23 below.

Table 4.23 Cooperation with modern practitioners (N = 30)

Categories	Respondents
No cooperation	20 (66.7%)
Have cooperation	3 (10.0%)
Cooperation just beginning	3 (10.0%)
Used to cooperate	4 (13.3%)
Total	30 (100.0%)

Table 4.23 indicates that the majority of traditional healers (66.7%) did not cooperate with modern practitioners in treatment or care of patients.

Have cooperation

Only 3 (10.0%) traditional healers said they cooperate with modern practitioners. Their responses were as follows:

- *Sometimes the nurse from the clinic refers patients with epilepsy to me and I refer those patients with sores in the chest to the clinic but this is not formal and there is no follow up.*
- *I refer patients who are pregnant especially because I am a Traditional Birth Attendant. I also go back to the clinic to ask questions when I feel stuck about my work.*

Cooperation is just beginning

Table 4.23 shows that 3 (10.0%) traditional healers expressed that they had just started having meetings with the clinic nurse. Specific responses were:

- *we have just had a meeting with the clinic nurse to be able to know each other.*
- *we have recently been called to the clinic by the nurse to discuss issues on AIDS and immunization of children.*

Used to cooperate

Table 4.23 indicates that 4 (13.3%) traditional healers said that they used to cooperate with the nurses in the clinic and the Village Health Workers (VHWs) but such relationships have stopped.

The following were their responses:

- *Nurses used to call us to the clinic with Village Health Workers where general problems were addressed but it seems they did not trust us and the cooperation stopped.*

- *We used to cooperate with the hospital staff but unfortunately the personnel at the hospital change frequently and the relationship stopped.*

The responses given in this item suggest that there is little support for traditional healers because, even where cooperation was started, the relationship did not last long. If meetings, discussions and training persisted, trust and confidence should have been built between the traditional healers and nurse practitioners in the clinic.

Item 27: Benefits that traditional healers get from cooperation

The responses which were given to this question by three traditional healers who currently cooperate with nurses in the clinic were:

- *the cooperation makes me feel recognized and supported by the clinic staff.*
- *patients benefit directly when they get well.*
- *I learn a lot from her experiences and we exchange ideas on health issues.*

Traditional healers (13.3%) who used to cooperate with nurses, but cooperation did not last said:

- *The cooperation helped us to know them better and their ways of treating disease.*
- *The meetings made us realize our goal together in the care of people during illness.*
- *We all learned together, they were supposed to refer to us and we also refer patients to them but they never referred patients to us.*

Those traditional healers who had just began meetings with clinic nurses gave the following

response:

- *It is difficult to say what benefits can come from these meetings and discussions because they have just started. We will see what happens when time goes on.*

Item 28: Benefits to modern practitioners through cooperation with traditional healers

Table 4.24 Benefits to modern practitioners through cooperation with traditional healers

(N = 10)

Categories	Responses	Respondents
Referral of patients	<ul style="list-style-type: none">- patients' lives saved- modern can answer better- nurse happy to cooperate	3 (10.0%)
Cooperation is beginning	<ul style="list-style-type: none">- shared ideas- to be observed- in future, may benefit	3 (10.0%)
Used to cooperate	<ul style="list-style-type: none">- knew us and our ways- brought nearer to us- modern can answer- hospitals learned	4 (13.3%)

Table 4.24 shows how traditional healers from the indicated categories responded to the above question.

Traditional healers who referred patients

These traditional healers gave the following responses:

- *referral of patients benefited the nurses because patients' lives were saved by treatment.*
- *modern practitioners can answer this question better than me.*
- *the nurse at the clinic is happy to cooperate with me because both of us help patients.*

Cooperation beginning

Those traditional healers who had just started working with nurses at the clinic gave the following responses:

- *we shared ideas on AIDS on the day we met.*
- *benefits are still to be observed*
- *in future they may benefit, currently, they do not trust us, they do not think that we can treat diseases, yet traditional healers have protected this nation against diseases and natural disasters long before the white men came.*

Used to cooperate

Those traditional healers who used to cooperate with nurses in the clinics said:

- *if cooperation continued, they would know us and our way of treating diseases.*
- *the meetings brought them nearer to us and this would enable us to work together for success.*
- *hospitals learned from traditional healers and this helped to build trust together between us.*
- *modern practitioners can answer the question better than me.*

Item 29 : Patients referred to modern practitioners by traditional healers

Table 4.25 Patients referred to modern practitioners by traditional healers (N = 30)

Diseases	Frequency
Gastro-enteritis	1 (3.3%)
Diabetes mellitus	1 (3.3%)
Hypertension	1 (3.3%)
Other	24 (80.0%)
Does not refer	3 (10.0%)
Total	30 (100.0%)

According to table 4.25, only 1 (3.3%) traditional healer said he referred patients with gastro-enteritis, diabetes mellitus and hypertension to modern practitioners. Most of the respondents (80.0%) said they referred patients with other conditions only. Of the respondents, 10 percent indicated that they had not referred any patients to modern practitioners. This coincides with the

response in item 15, where 3 (10.0%) traditional healers said they had not had any patient come back to claim that they did not respond to treatment, therefore patients were not referred to modern practitioners.

The conditions which were listed as 'other' were as indicated in table 4.26.

Table 4.26 Other conditions referred to modern practitioners (N = 24)

Conditions	Respondents
Pregnant women	6 (25%)
Prolonged illness	8 (33.4%)
Weak blood	5 (20.8%)
Dehydrated	5 (20.8%)
Total	24 (100.0%)

It is encouraging to note that traditional healers observe that pregnant women need to be referred to health facilities. If this practice can spread to other traditional healers, maternal mortality and neonatal mortality can be reduced.

Item 30: The type of patients that traditional healers treated referred by modern practitioners

Only 3 (10.0%) traditional healers mentioned that they treated patients referred by modern

practitioners. The cases they treated were cancer, epilepsy, *sejeso* and *litoromo*.

Many traditional healers (90.0%) said that modern practitioners do not refer patients to them. The reasons for not referring patients to them were given as follows:

- *modern practitioners feel that patients would rather die than refer them to traditional healers.*
- *they do not trust us, yet they want us to refer patients to them,*
- *they think we are not educated therefore we are unreliable, therefore, they do not appreciate our efforts.*
- *they do not believe in our practices and they think we do not know what we are doing. They should be reminded that even our great grandfather Moshoeshoe I had his healer.*

Obbo (1996 : 199) also observes that traditional healers “know that their medicine is dismissed as backward and unscientific in the dominant biomedical discourse espoused by the dominant elite”.

Item 31: Ways in which traditional healers felt that they could contribute to PHC

The responses were categorized according to the items shown in the table below.

Table 4.27 Ways in which traditional healers felt that they could contribute to PHC (N = 30)

Categories	Respondents
Already doing PHC	24 (80.0%)
Guidance needed	2 (6.7%)
Deal with social issues	4 (13.3%)
Total	30 (100.0%)

Already practising PHC

Most of the respondents (80.0%) felt that they were already engaged in PHC activities. Their verbatim responses were:

- *we have been doing a lot of good work, treating people and following in the footsteps of our ancestors who saved this nation from hazardous conditions, hence we are still a nation.*
- *our great grandfathers used traditional healing before us and we continue. If PHC is about good health, nobody in Lesotho can teach us that. PHC is not for modern practitioners only, it is for us all.*

Guidance needed

Only 2 (6.7%) traditional healers indicated that they would need to be guided on how they should contribute to PHC. Some verbatim responses included the following:

- *I do not know, we may need to be guided by those involved in PHC, since this is a concept from modern practitioners.*
- *only nurses talk about PHC, they can tell us on how to contribute, but nurses and doctors do not like us, they get angry with people who consult us.*

Deal with social issues

In response to this question, 4 (13.3%) traditional healers indicated that they also deal with social problems in addition to treatment and prevention of disease.

The responses given were:

- *we do a lot including prevention of theft which is a social issue.*
- *some people consult me because they want to take somebody's husband. I do not help such clients for fear of participating in antisocial activities.*

4.3 SUMMARY

The findings in this analysis indicate that there is no support to traditional healers to be involved in primary health care at the grassroots level. There is also little cooperation between traditional

healers and nurse practitioners. Traditional healers, however, feel that cooperation between traditional healers and nurse practitioners is necessary for the good of the clients they serve.

According to the findings, traditional healers generally refer patients to modern practitioners even though no patients are referred to them by modern practitioners.

The findings also reveal that traditional healers observe that they do well in social problems which include keeping the families together and in conditions where a person believes that he/she has been bewitched. The findings also indicate that traditional healers have trust in modern practitioners hence they also consult modern practitioners when they themselves are sick.

CHAPTER 5

DATA ANALYSIS FROM NURSE PRACTITIONERS

The purpose of data analysis, regardless of the type of data one has, and regardless of the tradition that has driven its collection, is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research project (Polit and Hungler 1993:329).

5.1 INTRODUCTION

This chapter begins with the analysis of data collected from nurse practitioners who work in the health centres /clinics from Maseru Health Service Areas. The process of data analysis began with raw data and was analysed within the framework of Leininger's theory which suggests that environmental and cultural factors influence health care delivery, patterns of care and responses to illness (George 1995:377).

5.2 FINDINGS

SECTION 1 BIOGRAPHICAL DATA

Item 1 : The gender of nurse practitioners who participated in the study

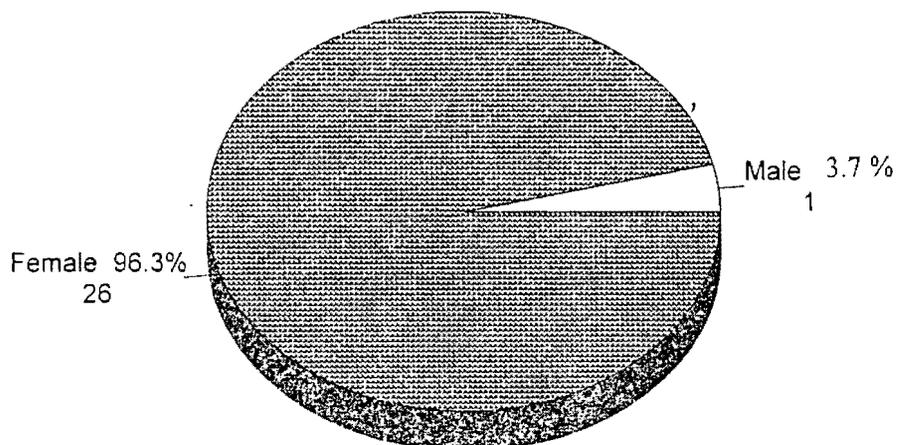


Figure 5.1. The gender of nurse practitioners who participated in the study (N = 27).

Figure.5.1 indicates the number of female versus male nurses interviewed. Only 1 (3.7%) nurse practitioner was a male while 26 (96.3%) were females. This was no surprise because traditionally, the nursing profession has been a female dominated profession and this is still the case in Lesotho.

Item 2 : Age distribution of nurse practitioners

Table.5.1 Age distribution of nurse practitioners (N=27)

Age distribution	Frequency
0 - 19 years	1 (3.7%)
20 - 39 years	9 (33.3%)
40 - 59 years	16 (59.3%)
60 and above	1 (3.7%)
Total	27 (100.0%)

The age distribution of the nurse respondents is indicated in table 5.1. Only 1 (3.7%) was between 0-19 years. The assumption is that one of the respondents must have made a mistake in selecting the right age. Usually people complete their nursing education at age 23 upwards. It was therefore not possible for somebody who is practising as a qualified nurse to be within 0-19 years old. In fact, 19 years is usually the entry age for professional training. This suggests that this age group should not have been included in the questionnaire. Of the respondents, 9 (33.3%) nurses were in the age bracket of 20 - 39 years while 16 (59.3%) were between 40 and 59 years old. This age group usually has more professional experience because of their length of time in the service. It is assumed that this was the appropriate age group with whom to discuss issues of collaboration because of their relevant experience. Only 1 (3.3%) nurse was 60 years and above. This is not surprising because in Lesotho, compulsory retirement from the civil service is 55 years. This particular nurse could have come from one of the non-governmental institutions.

Item 3 : Religious affiliation of nurse practitioners

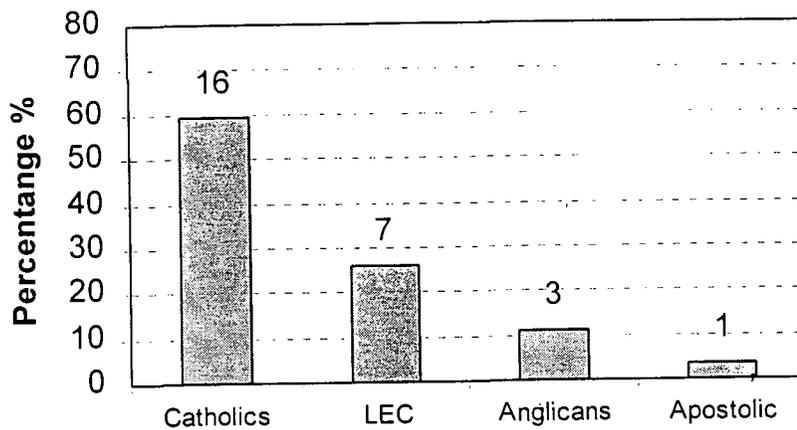


Fig. 5.2 Religious affiliation of nurse practitioners (N=27)

Figure 5.2 shows the distribution of the nurse respondents according to their religious denominations. Catholics were represented by 16 (59.3%), Lesotho Evangelical Church (LEC) by 7 (25.9%) while Anglicans were 3 (11.1%), member of Apostolic Faith Mission was 1 (3.7%). This is in line with religious affiliations of traditional healers in chapter 4, item 3 where Catholics were represented by 12 (40%) healers.

Item 4 : Marital status of nurse practitioners

Table 5.2 Marital status of nurse practitioners (N=27)

Marital status	Frequency
Married	20 (74.1%)
Widowed	1 (3.7%)
Single	6 (22.2%)
Total	27 (100.0%)

According to table 5.2, 74.1% of the respondents were married, 22.2% were single while 3.7% were widowed. No divorcees were noted.

Item 5 : Professional qualifications of nurse practitioners

Table 5.3 Professional qualifications of nurse practitioners (N=27)

Qualifications	Frequency
Registered nurse	25 (92.6%)
Enrolled nurse	1 (3.7%)
Other	1 (3.7%)
Total	27(100.0%)

Table 5.3 gives the type of qualification of the individual nurses who completed the questionnaire. Many (92.6%) of the respondents were registered nurses, one (3.7%) was an enrolled nurse while the other one (3.7%) was 'other'. The one (3.7%) for 'other' could have been a nurse clinician. Most of the nurses with this qualification work in the clinics since they have been trained in diagnosing and prescribing and she could also have been a public health nurse. Public health nurses included in this study did not indicate their extra qualifications. This suggests that this question could have been worded in a different way to allow for those nurses with extra qualifications to indicate it in their responses.

Item 6 : Area of Residence of nurse practitioners

Table 5.4 Area of residence of nurse practitioners (N =27)

Area of residence	Frequency
Urban	14 (51.9%)
Peri – urban	7 (25.9%)
Rural	6 (22.2%)
Total	27 (100.0%)

Table 5.4 indicates the distribution of the nurse respondents according to their areas of residence. Maseru Health Service Area covers urban, peri-urban and rural areas. Most (51.9%) of the respondents lived in the urban area, 25.9 percent lived in the peri-urban while 22.2 percent of the nurse respondents came from the rural area. According to the Bureau of

Statistics, the population of Maseru District is 385,869 (1996 census). The increase of the population is due to the influx of people moving into towns to look for jobs. The Ministry of Health has also built filter clinics around Maseru in order to decongest the referral hospital (Q.E.11). This has therefore increased the number of nurses who live in the urban area.

Item 7 : Work Experience of nurse practitioners

Table 5.5 Work experience of nurse practitioners (N=27)

Work experience	Frequency
0 - 5 years	4 (14.8%)
6 - 10 years	2 (7.4%)
11 - 15 years	7 (26.0%)
16 - 20 years	8 (29.6%)
21 and over	6 (22.2%)
Total	27 (100.0%)

Table 5.5 gives the distribution of the nurse respondents according to their level of experience. Of the respondents, 4 (14.8%) had between 0 and 5 years of experience, 2 (7.4%) nurse respondents had worked for 6 to 10 years and 7 (26.0%) had been in the service for a maximum of 15 years. Many respondents, 8 (29.6%) had worked for 16 –20 years. Those with over 21 years in the service were 6 (22.2%). Table 5.1 also indicated that the majority of these nurses were above 40 years of age which suggests more work experience. Collaboration

with traditional healers therefore was an ideal topic for discussion with this group because of their work experience.

SECTION 2 PRIMARY HEALTH CARE

Item 8 : Number of clients usually seen at individual clinics

Table 5.6 . Number of clients usually seen at individual clinics (N=24)

No. of clients	No. of clinics	Percentage
1 -20	3	13.0%
21 – 40	6	25.0%
41 – 60	2	8.0%
61 – 80	2	8.0%
80 and above	11	46.0%
Total	24	100.0%

Table 5.6 indicates the number of clients usually seen daily by various nurses at individual clinics. The clinics which are reported to serve 1 -20 clients were three, while six clinics served 21 - 40 clients and two clinics reported an attendance of 41 - 60 clients a day. In addition, two clinics also reported seeing 60 - 80 clients daily. Most (11) of the clinics, attend to more than 80 clients per day. The number of clients seen in the clinic is significant

in creating collaboration between traditional healers and nurse practitioners. Where training and meetings have to take place the workload of the clinic has to be considered. In item 10, eleven clinics reported that they each had one registered nurse. Where 80 clients have to be seen in a clinic, whether a doctor visits that clinic daily or not, other activities related to collaboration with traditional healers may not be realistic.

Item 9 : Frequency of doctor’s visits to the clinic

Table 5.7 Frequency of doctor’s visits to the clinic (N = 23)

Doctor’s visits	Frequency
Daily	10 (43.5%)
Monthly	13 (56.5%)
Total	23 (100.0)

Table 5.7 suggests how the doctors’ visits are scheduled for the clinics. This has a bearing on the support that the nurses in the clinics could give to the traditional healers. The assumption is that where there is little support for the nurses in the clinics, such nurses are unlikely to support other groups such as the traditional healers. Only 10 (43.5%) clinics are reported having daily visits by the doctors while 13 (56.5%) clinics have monthly visits from the doctors. The clinics which are visited daily by the doctors in table 5.7 are both government and non -governmental clinics. The purpose of daily visits is to decongest the referral hospital in Maseru which is often overcrowded. The four nurses who did not respond to the question

could be the public health nurses who are supervisors and do not work in the clinics, or nurses who work in private clinics and are not visited by the doctors.

Item 10 : Number of registered nurses in each clinic

Table 5.8 Number of registered nurses in each clinic (N = 24)

No of registered nurses	Frequency
1	11 (45.8%)
2	9 (37.5%)
3	4 (16.7%)
Total	24 (100.0%)

Table 5.8 indicates the distribution of registered nurses in the clinics which participated in the study. Of the respondents, 11 (45.8%) said there was only one registered nurse in the clinic, while 9 (37.5%) had two registered nurses in the clinic and 4 (16.7%) indicated that they had three registered nurses. The clinics which had more than one registered nurse were in the peri-urban and urban areas which are densely populated and therefore, have a heavy workload hence more professional staff is required. The staffing pattern of the clinic can also determine whether collaboration between traditional healers and modern practitioners becomes a success. Originally, the Government of Lesotho had planned to have one nurse clinician, one nurse/midwife and one nursing assistant in the clinic to enhance primary health care activities. This did not materialize because of shortage of nursing personnel.

Item 11 : Number of enrolled nurses in each clinic

Only four clinics were reported to have one enrolled nurse each. There are few enrolled nurses in Lesotho because the country no longer trains enrolled nurses. As a result their numbers have greatly decreased.

Item 12 : Number of nursing assistants in each clinic

Table 5.9 Number of nursing assistants in each clinic (N =20)

No. of nursing assistants	Frequency
1	13 (65.0%)
2	2 (10.0%)
3	5 (25.0%)
Total	20 (100.0%)

Table 5.9 gives the distribution of the nursing assistants in each clinic. Most (13) of the clinics had only one nursing assistant while two clinics had two nursing assistants and five clinics were manned by three nursing assistants. When Lesotho adopted the primary health care strategy, the agreement was to have each clinic manned by a nurse clinician, a registered nurse/midwife and a nursing assistant. This was not accomplished because of shortage of nurses. The filter clinics which had more than two nursing assistants were planned to operate twenty-four hours to reduce the congestion in the hospitals around the towns.

Item 13 : The way in which patients are treated by nurses

Table 5.10 The way in which patients are treated by nurses (N = 24)

How patients are treated	Frequency
As individuals	3 (12.5%)
As family members	15 (62.5%)
As both	6 (25.0%)
Total	24 (100.0%)

Table 5.10 suggests the approach taken by the individual nurses when treating patients. Of the nurse respondents, 3 (12.5%), nurses said that they treat patients as individuals while 15 (62.5%) nurse respondents indicated that they treat the patients as members of the family and 6 (25.0%) showed that they treat the patients as both individuals and members of the family. Treating a patient as an individual means that the environment within which the patient lives is not taken into consideration during treatment. Treating the patient as a family suggests that other factors around the family are considered during treatment. Those nurses who treat a patient as a member of the family are probably aware of Leininger's theory which suggests that factors around the environment affect health care and the response to illness (Leininger 1984b:42). Brandt (1984:19) also notes that "holistic care of patients necessitates involving their families in the care. ... no patient can achieve total wellness if the family relationship deteriorates because of illness".

Item 14 : Explain why you treat the patient as an individual or as a member of the family

The 12.5 percent who said they treat patients as individuals gave the following reasons :

- patients often come alone to the clinic
- patients are treated according to their individual needs because their problems are unique

Those nurses who said they treat patients as members of the family (62.5%) gave the following reasons:

- primary health care and nursing both begin at home, where more information about the patient's illness can be obtained from their families. It is therefore important for the patient to share his/her convalescence stage with the relatives who look after him/her.
- the family needs to be involved to be able to support the patient
- illness of one member of the family affects the finances of the family and also affects the members psychologically. Therefore, it is important to involve them in the care of the sick.

Those who said they treat the patients both as individuals and as members of the family (25.0%) gave a combination of reasons. They mentioned that for confidentiality, patients are treated as individuals but for conditions such as stress, there is a need to involve the family in the care.

Item 15 : The involvement of significant others in the care of patients.

Respondents in this section mentioned more than one way of involving significant others in the care.

Table 5.11 The involvement of significant others in the care of patients (N = 27)

Involvement		Frequency			
Item		Yes	No	Total	N
15.1	Does not involve them	1 (3.7%)	26(96.3%)	27(100%)	N = 27
15.2	Explain the cause of disease	22 (81.5%)	5 (18.5%)	27 (100%)	N = 27
15.3	Explain how medicine is taken	24 (88.9%)	3 (11.1%)	27 (100%)	N = 27
15.4	Other involvement	14 (51.9%)	13 (48.1%)	27 (100%)	N = 27

Item 15.1 Does not involve them

Only 1 (3.7%) respondent who answered the question said he does not involve the significant others in patient's care. The question was taken to be the introduction to the questions that followed. The responses to the questions which followed were positive.

Item 15.2 Explain the cause of disease

Table 5.11 shows that 22 (81.5%) respondents said that they usually explain the cause of disease to significant others. This response is encouraging because knowledge of the cause of disease can lead to preventive measures being taken in future.

Item 15.3 Explain how medicine is taken

According to table 5.11, 24 (88.9%) nurse respondents indicated that they involve the significant others by explaining how medicine should be taken. This is a very important aspect of involvement because if medication is not taken correctly, the response to treatment may not be satisfactory. For example, high doses of aspirin or prolonged use especially if taken on an empty stomach may lead to epigastric problems occasionally leading to gastrointestinal bleeding (Ames and Kneisl 1988:55).

Item 15.4 Explain follow up

The same percentage (88.9%) of the respondents said they usually explain to the significant others when to come for follow up. Follow up of patients is important, especially for diseases such as tuberculosis. If significant others are not aware of the follow up date, the defaulter rate may rise and this can lead to drug resistance (Cookfair 1996:465).

Item 15.5 Other methods of involving significant others

A significant percentage (51.9%) of the respondents indicated that they involve significant others through other methods. The explanation of other methods is explained in item 16 below.

Item 16 : Explanation of other methods in 15.5 above

The question demanded that the respondents who selected other should explain the methods used. The following methods were explained:

- sometimes explaining the type of exercise where necessary
- referral of a patient where necessary
- education on the type of food to be taken at home
- information on what to expect from treatment and on the care needed at home.

Some patients need to continue exercises while at home following discharge from the hospital. For example, after mastectomy, Harkness and Dincher (1996:854-857) note that the patient needs to do exercises on the affected arm in order to restore the use of the affected arm as soon as possible to prevent contractures. It is also important to let the significant others know how to care for the patient at home. For example, a patient who has just recovered from burns needs to clean the affected area with mild soap and water and apply moisturizer to the healed burn area in order to avoid drying of the skin (Harkness and Dincher 1996:1087).

**SECTION 3 INVOLVEMENT OF TRADITIONAL HEALERS IN PRIMARY
HEALTH CARE**

Item 17.1 : Extent to which nurse practitioners involved traditional healers in PHC

Table 5.12 Extent to which nurse practitioners involved traditional healers in PHC.

Item	Involvement	Yes	No	Total	N
17.1	Refer patients to traditional healers	7 (77.8%)	2 (22.2%)	9 (100%)	N = 9
17.2	Hold gatherings with traditional healers	19 (70.4%)	8 (29.6%)	27 (100%)	N = 27
17.3	Other ways of involvement	13 (48.1%)	14 (51.9%)	27 (100%)	N = 27

Item 17.1 : Referral of patients to traditional healers

According to table 5.12, only 7 (77.8%) of the nine nurse respondents who answered the question said they refer patients to traditional healers. Only 2 nurses clearly said they do not refer to traditional healers. The researcher assumed that other nurses may still refer patients to traditional healers, but could have been afraid to say so because this has not been formally allowed. They probably fear being accused of avoiding the normal protocol of referral to the hospitals. At present, the Ministry of Health licenses the traditional healers because the traditional healers' Council is not yet fully operational (Gill 1994:85). This implies that effective ways of ascertaining the abilities of traditional healers are non-existent and this can form a barrier to collaboration and more importantly to referral of patients to traditional healers.

Item 17.2 : Having gatherings to discuss health issues

The respondents who indicated that they hold meetings to discuss health issues were 19 (70.4%) while those who did not were only 8 (29.6%). Discussing health issues with traditional healers reflects a positive attitude towards sharing information. It also presents an opportunity to give health education and to make traditional healers aware of some of the preventive measures which can be taken to avert disease. For example, Green (1988:1127) notes that a number of traditional healers give enemas to children with infectious diarrhoea, thus exacerbating dehydration and threatening the lives of children. According to Forum for primary health care (1996:10), a campaign in Swaziland with traditional healers to treat diarrhoea with oral rehydration solution has resulted in the reduction of deaths caused by diarrhoea. Cooperation with traditional healers in some countries such as Swaziland therefore, is becoming a success. Traditional healers can also take the opportunity to share what they know with the nurses.

Item 17.3 and 18 : Other ways of involvement

Item 17.3 and item 18 are discussed together. According to table 5.11, 13 (48.1%) of the nurses indicated that they involve traditional healers in other ways. The ways were explained as follows:

- holding workshops for traditional healers to share experiences and give them training especially those who are Village Health Workers (VHW).

Holding workshops and training traditional healers is an important aspect of disseminating health information. Buch in Mahoko (1997:5) notes that

we have failed to develop any successful campaigns for example, on the use of oral rehydration solution to prevent deaths from diarrhoea - the biggest killer of children in the developing world.

Another example which suggests that traditional healers are ready to learn and can be useful is given by Pitt in the Valley Trust (1998:7) who said traditional healers are involved in programmes such as tuberculosis, oral rehydration, nutritional programmes and distribution of condoms.

Item 19 : Effective utilization of traditional healers in primary health care

Table 5.13 Effective utilization of traditional healers in primary health care. (N = 27)

Item	How traditional healers can be utilized in PHC	Yes	No	Total
19.1	Prevention of common illness	24 (88.9%)	3 (11.1%)	27 (100%)
19.2	Education of community	25 (92.6%)	2 (7.4%)	27 (100%)
19.3	Support on home based care	23 (85.2%)	4 (14.8%)	27 (100%)
19.4	Other	19 (70.4%)	8 (29.6%)	27 (100%)

Item 19.1 : Prevention of common illnesses

According to table 5.13, a high percentage (88.9%) of nurses indicated that traditional healers could be utilized in the prevention of common illnesses. With this positive response, the assumption is that the nurses realize the potential which traditional healers have in PHC and

perhaps the need for collaboration. Dheyongera (1994:16) observes that traditional healers play a significant role because they

- can fill the gap created by health personnel
- are effective in psychosomatic diseases, interpersonal relations including counselling.
- are not hampered by transport in rural areas.

These qualities give traditional healers the potential to be used in the prevention of common illnesses.

Item 19.2 : Education of the community

Most (92.6%) of the nurses were of the opinion that traditional healers could be utilized effectively in the education of the communities on health issues. When the educator speaks the same language with the trainees and is knowledgeable of their culture and beliefs, health education has a better opportunity to succeed. Traditional healers have these qualities and are also part of the community. Therefore, if a high percentage of traditional healers are involved in educating the community, a high success rate can be anticipated. Dr Friedman in Clarke (1998:8) makes the observation that traditional healers are influential in improving peoples' health and succinctly states:

traditional practitioners are an integral part of the culture of the society.

Just as with other individuals, they are part of a dynamic social change.

My experience has suggested that in many respects they are leaders of social change and are early rather than late adapters of new ideas.....

Traditional practitioners are enormously influential in improving peoples' health.

Item 19.3 : Support on home based care

Nurses who felt that traditional healers could be utilized as support in home-based care for HIV/AIDS were 23 (85.2%). This high percentage is encouraging. HIV/AIDS is increasing at an alarming rate in Lesotho. According to Maw (1998:12), in 1998, there were 3, 242 reported cases of AIDS. This is very high in a country as small as Lesotho. This figure does not include unreported cases. This implies that the health care professionals may not be able to give the necessary care to those who are very sick because of the shortage of manpower and other resources. In addition, the hospital space may not cope with this increase, those who can not be admitted will need to be cared for at home. Traditional healers could therefore come in as support group to those nursed at home.

Item 19.4 : Utilization of traditional healers in other ways

According to table 5.13, 19 (70.4%) of the nurse practitioners said that traditional healers could be utilized in other ways. These other methods are explained in item 20 below.

Item 20 : Explanation of other methods of involving traditional healers in PHC

According to 70.4 percent of nurses who said other methods could be utilized, the following methods were given:

- could be trained as AIDS counsellors
- utilized in health education. In item 19.2, education of the community was mentioned but here, specifically, is clarified as health education
- utilized in encouraging the referral system from the communities to the health centres

These responses from the nurse practitioners give the impression that traditional healers could be utilized for a range of services in PHC if collaboration between traditional healers and nurse practitioners could be a success. With the current health problems, the above mentioned services are critical in health care. The Valley Trust experience has indicated that traditional healers can be utilized for various services. For example, Pitt (1998:3) notes that they involve traditional healers amongst others in the Tuberculosis Programme, and in a Social Plant Programme.

Item 21 : In your opinion why do people consult traditional healers?

According to 81.5 percent of nurse respondents, the reasons why people consult traditional healers were as follows:

- when they believe they have been bewitched
- because people have more confidence in traditional healers than in modern practitioners
- traditional healers are nearer to the people and they are available in times of need because of their cultural beliefs and customs
- because they think that traditional healers can tell the actual cause of the disease.

Traditional healers live in the communities, they are an integral part of the culture, who are available in times of need, hence they consult traditional healers when sick (Clarke 1998:8). Fako in Mahoko (1997:20) also observes that people consult traditional healers to find out the actual cause of illness and also to get a meaningful explanation of the problem. Skjonsberg (1989:167) also alludes to the fact that witchcraft causes suffering that cannot be explained and there are those traditional healers who claim they can neutralize the actions caused by the witches. This explains why people consult traditional healers when they think they have been bewitched.

Asked why people consult modern practitioners, 66.7 percent of the nurse respondents indicated that modern practitioners are consulted for the following reasons :

- if the disease is thought to be of a natural origin
- when traditional medicine has failed
- if they think the disease can be cured by modern practitioners
- to alleviate pain
- when they have been sensitized through health education and becoming civilized
- some people trust modern practitioners

The first response suggests that people in Lesotho still believe that illness results from natural causes and/or man's ability to manipulate the natural environment so as to harm another person. Ruch and Anyanwa (1981:113) indicate that "African belief in witchcraft has a powerful impact and creates a climate of fear and terror and can produce pathological conditions just as anger and anxiety". It is encouraging also to note that health education is making an impact on the attitudes of people towards disease and the choice of a practitioner

when an individual is sick. Another positive step, is when people know who to consult and for what condition.

Despite cultural beliefs and customs, some people have been socialized into modern practices hence they trust modern practitioners. The responses above show that people believe that certain diseases can be handled by modern practitioners. Sechaba Consultants in Moji and Rogas (1993:19) note that “people of Lesotho look for deep and immediate causes of disease. Immediate causes relate to infections and injuries”. Modern practitioners will usually be consulted for these.

Item 22 : Conditions which traditional healers treat effectively

Table 5.14 Conditions which traditional healers treat effectively (N = 27)

Item	Conditions which traditional healers can treat	Yes	No	Total
22.1	AIDS	3 (11.1%)	24 (88.9%)	27 (100%)
22.2	Tuberculosis	3 (11.1%)	24 (88.9%)	27 (100%)
22.3	Gastro-enteritis	4 (14.8%)	23 (85.2%)	27 (100%)
22.4	Other	15 (55.6%)	12 (44.4%)	27 (100%)

Item 22.1 AIDS

Table 5.14 shows the number of nurses who believe that traditional healers are capable of treating AIDS. Of the respondents, 3 (11.1%) said that traditional healers are effective in the treatment of AIDS. Although some traditional healers claim that they can cure AIDS, no scientific evidence has been found that this is the case. Maw (1998:2) still refers to AIDS as “the invisible epidemic”. Perhaps this is because there is still no cure for it. Mzimakwe

(1996:313) notes that the rising incidence of diseases whose causes and treatment are not known, such as AIDS and cancer, has led to many people consulting traditional healers because of the disappointment they have with western medicine.

Item 22.2 Tuberculosis

Of the respondents, 3 (11.1%) noted that traditional healers are effective in the treatment of Tuberculosis as seen in table 5.14. Tuberculosis has the highest morbidity rate and is still one of the most prevalent diseases in Lesotho. According to Ntšekhe et al (1997:13), Maseru Health Service Area has the highest rate of Tuberculosis in the country at 720/100,000 population while the national average for Tuberculosis is 297/100,000. Traditional healers refer to TB as *sejeso*. This means that modern practice utilise its own medication and traditional healers also have their own protocol in the treatment of disease. Research efforts need to be made to find out what contributes to the high increase of Tuberculosis and which methods or protocols can be effective in treating TB.

Item 22.3 Gastro-enteritis

Table 5.14 indicates that 14.8 percent of nurses said that traditional healers are effective in the treatment of gastro-enteritis. Gastro-enteritis is a common illness in Lesotho. According to Queen Elizabeth II records, in 1999, the following children as seen in table 5.15 were seen with diarrhoea at the paediatric clinic :

Table 5.15. Statistics of diarrhoea in children at the paediatric clinic at Queen Elizabeth II

Hospital in 1999

Month	Diarrhoea cases
January	129
February	94
March	116
April	52
May	24
June	49

The observation is that during the summer months, (January to March) diarrhoea cases increase and in April the number of cases begin to decrease. In item 19, table 5.13, twenty-four (88.9%) of nurse respondents said that traditional healers could be utilized to prevent common illnesses. This can be an opportunity for nurses to demonstrate oral rehydration therapy to traditional healers in order to prevent and treat diarrhoea.

Item 22.4 Other

The nurses who said traditional healers could effectively treat other diseases were 55.6 percent. These other conditions are explained in item 23 below.

Item 23 Explanation of other conditions that traditional healers can treat effectively

The following are the other conditions which according to nurses, traditional healers can treat successfully. According to 55.6 percent of the nurse respondents, traditional healers have expertise in:

- cancer
- medicine given during pregnancy (pitsa)
- upper respiratory tract infection
- conditions arising as a result of cultural beliefs
- infertility and mental illness

Those nurses who said they did not believe that traditional healers can manage conditions effectively indicated that traditional healers keep patients too long before they refer them to a health facility. They also said that traditional healers cause more problems. For example, they treat diarrhoea with a laxative which causes excessive loss of fluid. Green (1988:1127) supports this notion by observing that traditional healers treat infectious diarrhoea with enemas.

SECTION 4: SUPPORT SYSTEM AVAILABLE TO TRADITIONAL HEALERS

Item 24 Support given to traditional healers by nurse practitioners

Table 5.16 Support given to traditional healers by nurse practitioners (N =27)

Item	Support to traditional healers	Yes	No	Total
24.1	No support	9 (33.3%)	18 (66.7%)	27 (100%)
24.2	Give training	9 (33.3%)	18 (66.7%)	27 (100%)
24.3	Hold gatherings	7 (25.9%)	20 (74.1%)	27 (100%)
24.4	Other	3 (11.1%)	24 (88.9%)	27 (100%)

Item 24.1 No support

According to table 5.16, 9 (33.3%) of the nurse practitioners said that they give no support to traditional healers. In Lesotho, most of the clinics are manned by one registered nurse as seen in item 10, table 5.8, where 11 clinics said they had only one registered nurse. The lack of support to traditional healers could be a result of work overload. The activities in the clinic among other things include ante natal clinic (ANC), post natal clinic, well baby clinic and immunization, infertility clinic and family planning. This gives an idea of how busy the nurses in the clinics are.

Item 24.2 Give them training

As indicated in table 5.16, only 9 (33.3%) of the nurses said that they give traditional healers training. This is a matter that needs attention. For example, training in early referral could

solve a number of problems. Hess (1998:6) in support of this notes “that traditional healers are the first contact and front line service provider and they also help by referring patients to the modern sector”.

Item 24.3 Hold meetings

Only 25.9 percent of nurses said they have meetings with traditional healers. This is in contradiction to the response in item 17.2, table 5.12, where 70.4 percent of nurses said they hold gatherings with traditional healers to discuss health issues. The reason for this difference is not clear, but it could mean that support to traditional healers was interpreted by nurses as acknowledging their participation in health issues. As acknowledging healer’s expertise is still not an official policy, nurses may not want to commit themselves to supporting healers.

Item 24.4 Other

A small percentage (11.1%) of nurses said they support traditional healers in other ways which are listed in item 25 below.

Item 25 Explanation of other ways used to support traditional healers.

The other support systems given by nurse practitioners to traditional healers were explained as follows:

- traditional healers come as individuals to the health centre to discuss their individual problems.
- the clinic is currently doing a needs assessment to prepare for support

- traditional healers bring some of their patients to the clinic for advice on how to manage them.

It is encouraging to note that some of the traditional healers go to the health centres for individual advice as well as for advice on how to manage their patients. This is the ultimate goal of training traditional healers and cooperating with them in health care delivery.

Item 26 : Referral of patients who do not respond to treatment to traditional healers by nurse practitioners

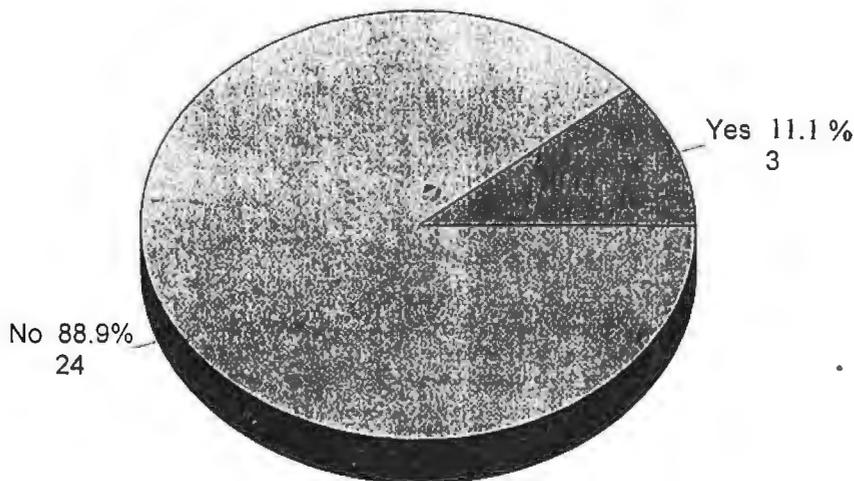


Figure 5.3 Referral of patients who do not respond to treatment to traditional healers by nurse practitioners (N=27)

As figure 5.3 depicts, only 11.1percent of nurse practitioners said they refer patients to traditional healers while 88.9 percent said they do not refer to traditional healers. One of the nurses said:

there is no point in referring patients to the traditional healers because they will still end up there anyway especially if they did not go to the traditional healer before coming to the clinic.

This response by this nurse gives some emphasis to the notion that people will consult a traditional healer when modern practice has failed or vice versa. This was indicated in item 21. The small percentage (11.1%) of nurses who refer patients to traditional healers could be a result of some nurses fearing to disclose that they do refer to traditional healers lest they be accused of bypassing the agreed upon protocol of referral to modern practitioners.

This finding gives rise to concern as although the nurses have indicated that they refer patients to traditional healers, the traditional healers say that nurses do not refer patients because no referrals are made to them. In chapter 4, item 30, traditional healers said that “modern practitioners do not trust us, yet they want us to refer patients to them”. Obbo (1996:199) also observes that traditional healers are aware that their treatment is dismissed as backward and unacceptable.

Item 27 : If yes to referral explain why

The 11.1 percent who refer to traditional healers gave the following reasons:

- refer psychiatric patients who have deep rooted cultural beliefs.
- refer those who have not responded to treatment because I know that they will anyway go to traditional healers, so I might as well refer them.
- to fulfil a psychological need for those who believe they have been bewitched.

These responses suggest that the nurses are also aware of the role of traditional healers and their capabilities in society. They are aware that the psychological need of the clients can be met by the traditional healers. Booyens (1991:491) notes that “some studies indicate that good results have been observed with traditional healers treating stress-induced psychosocial and psychophysiological problems and mild neurotic disorders”.

Item 28 : If no explain why

According to the 88.9 percent of nurse practitioners (figure 5.3) who do not refer patients to traditional healers, the reasons for not referring patients to traditional healers were as follows:

- have not seen anybody who could not be treated with modern medications
- currently, patients are referred to medical doctors. There is no law which protects the nurse practitioners who refer patients to traditional healers. Patients do refer themselves to traditional healers
- contact with traditional healers is not yet stable. There has to be a lot of community involvement and the community has to feel free to use both traditional healers and modern practitioners.
- we have not identified any traditional healers in this area.
- usually patients come to us having been to traditional healers first. There would be no point in us referring them back to traditional healers.

The reasons brought forward for nurses not referring to traditional healers are valid especially when there is no law that protects the nurses, as they have indicated. This is bound to put the

nurse practitioners in a dilemma as far as referral of patients to traditional healers is concerned.

Item 29 : Patients referred to traditional healers by nurse practitioners

Table 5.17 Patients referred to traditional healers by nurse practitioner (N =27)

Item	Diseases referred to traditional healers	Yes	No	Total
29.1	Tuberculosis	1 (3.7%)	26 (96.3%)	27 (100%)
29.2	AIDS	2 (7.4%)	25 (92.6%)	27 (100%)
29.3	Hypertension	3 (11.1%)	24 (89.9%)	27 (100%)
29.4	Diabetes	8 (29.6%)	19 (70.4%)	27 (100%)
29.5	Diarrhoea	2 (7.4%)	25 (92.6%)	27 (100%)
29.6	Other	9 (33.3%)	18 (66.7%)	27 (100%)

Item 29.1 : Referral of Tuberculosis patients

Only 1 (3.3%) of the respondents indicated that he refers patients with TB to traditional healers. There has not been any evidence that traditional healers have been successful with the treatment of TB. Maseru Health Service Area has the highest rate of TB (Ntšekhe et al 1997:13). This suggests that concerted efforts should be taken by all including traditional healers to prevent TB and follow up those that are already on treatment. Since traditional healers are already health care providers, their support can be solicited in the area of follow up and monitoring of TB patients.

Item 29.2 : Referral of patients with AIDS

According to table 5.17, only 2 (7.4%) nurse practitioners said they refer patients with AIDS to traditional healers. Some traditional healers claim that they can cure AIDS but there has not been any evidence to this effect. AIDS continues to increase despite the claims made by some of the traditional healers. Referral of patients with AIDS to traditional healers can be dangerous if traditional healers are not knowledgeable about the disease. In item 19.3, 23 (85.2%) nurses indicated that traditional healers could be utilized as support in home based care and as AIDS counsellors. This suggests that efforts should be strengthened to educate all people including traditional healers on preventive measures and on management of people with AIDS in the community.

Item 29.3 : Referral of patients with hypertension

Table 5.17 indicates that 3 (11.1%) nurses said that they refer patients with hypertension to traditional healers. Hypertension has become a problem in Lesotho. For example, in June 1999, 330 hypertensive patients were seen at the polyclinic in Q.E.II hospital (Queen Elizabeth II records). In the conversation, one of the traditional healers said she was treating one of the nurses for hypertension.

Item 29.4 : Referral of patients with diabetes

As indicated in table 5.17, 8 (29.6%) respondents said that they refer patients with diabetes to traditional healers. It is interesting to note that a higher percentage of nurses are willing to refer patients with diabetes to traditional healers. Diabetes mellitus is also noted to be on the

increase in Lesotho. In June 1999, 362 diabetic patients were seen at the polyclinic in Q.E.II hospital (1999 hospital records). It would also be interesting to know why they refer diabetic patients to traditional healers more often than TB or AIDS patients.

Item 29.5 : Referral of patients with diarrhoea

Only 2 (7.4%) nurses said they refer patients with diarrhoea to traditional healers. This is in contradiction to table 5.14, item 22.3, where 14.8 percent of nurses said that traditional healers can treat gastro-enteritis effectively. Perhaps some of these nurses are not willing to refer patients with diarrhoea to traditional healers because there has been no policy agreement on referral of patients to traditional healers. Table 5.14 in item 22.3 depicts the number of children with diarrhoea seen over six months at Q.E.II Hospital paediatric clinic.

Item 29.6 and 30 : Referral of patients with other conditions

As indicated in table 5.17, 9 (33.3%) nurse respondents said that they refer patients with other conditions to traditional healers. The conditions are listed in item 30 as cancer, infertility, STDs, psychological problems and those who are difficult to diagnose. Booyens (1991:491) notes that "some studies indicate that traditional healers have treated with success stress-induced psychosocial and psychophysiological problems".

Item 31 : Patients treated by nurses referred by traditional healers

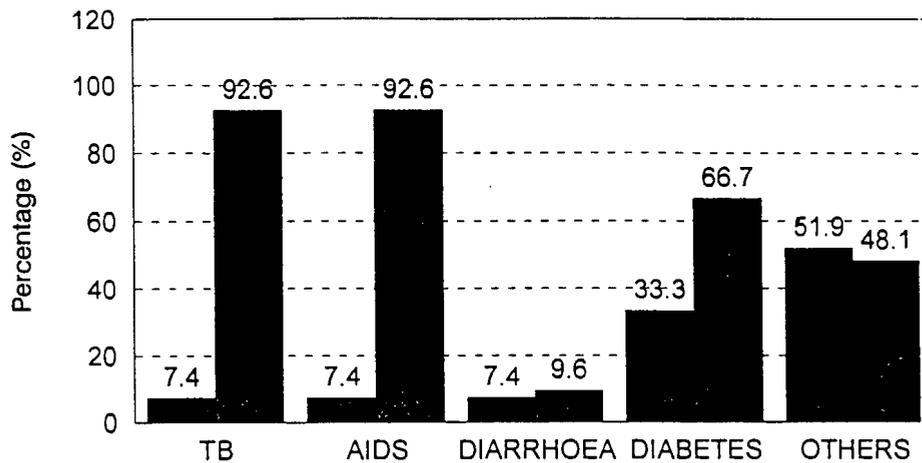


Figure 5.4 Patients treated by nurses and referred by traditional healers.

Figure 5.4 shows that only 7.4 percent of nurses said they treated patients with TB, AIDS and diarrhoea referred by traditional healers. Nine (33.3%) nurses indicated that they have treated patients with diabetes from traditional healers while 14 (51.9%) nurses said they had treated other diseases referred to them by traditional healers. The percentage of nurses (33.3%) who treated diabetic patients referred by traditional healers is very close to 29.6 percent of nurses in item 29.4 who referred diabetic patients to traditional healers. This could suggest that a planned referral system could lead to discussions and education of traditional healers on diabetes mellitus for the benefit of the patients.

Item 32 : List of other conditions referred by traditional healers

The other conditions referred by traditional healers to nurse practitioners were listed as follows: gastro-enteritis, epilepsy, hypertension, pneumonia, mental problems, malnutrition, peptic ulcers, upper respiratory tract infection and STDs. It is encouraging to note that STDs

is among the conditions referred to nurse practitioners because AIDS and STDs are closely related and this could help in diagnosing AIDS cases in the early stages of the disease.

Item 33 : Traditional healers accompanying patients to the clinic

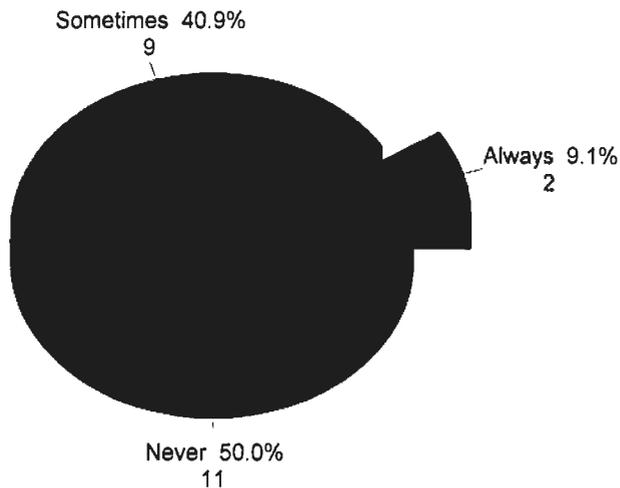


Figure 5.5 Traditional healers accompanying patients to the clinic (N =22)

Figure 5.5 indicates that, 50 percent of nurses said that traditional healers never accompany their patients to the clinic, while 40.9 percent said that sometimes they do accompany patients to the clinic, and only 9.1 percent said traditional healers always accompany their patients to the clinic. It is encouraging to observe that many of traditional healers do accompany their patients to the clinic. This could be an opportunity for the nurses and traditional healers to meet and discuss the patients' problems and treatment, thus sharing ideas even for the future follow up of patients.

Item 34: Clinic programme to train traditional healers

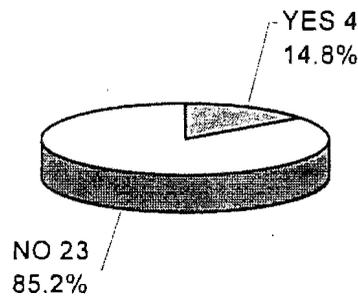


Figure 5.6 Clinic programme to train traditional healers (N=27)

Figure 5.6 indicates that, 14.8 percent of the respondents said that they have a programme for traditional healers, while 85.2 percent said they do not have a programme for traditional healers. In item 24.2, 33.3 percent of nurse practitioners said that they give traditional healers training, and in item 24.3, 25.9 percent of the respondents said they hold meetings with traditional healers. What accounts for the inconsistency in the responses is not clear, but it could mean that some nurses only have adhoc contact with traditional healers.

Item 35: Explanation of the programme for traditional healers

According to 14.8 percent (Figure 5.6) of nurse respondents who had programmes for traditional healers, the programmes included:

- Signs and symptoms of common illnesses and their prevention
- First aid and referral of patients to health facilities

- support for home based care on HIV/AIDS
- control of diarrhoeal diseases, acute respiratory infections (ARI) and STDs.
- demonstration on mixing Oral Rehydration Solution (ORS) and its administration.

The above explanation suggests that those nurse practitioners who have a programme for traditional healers are doing a comprehensive, commendable job. Many communities could benefit if this type of work could be strengthened.

Item 36 : How often programmes are offered

The programmes available were offered monthly by 11.1 percent of the nurse respondents. The response, however, does not coincide with the responses to item 34, where 14.8 percent said that they have a programme for traditional healers. This could mean that some of the nurses only have contact with traditional healers when it is convenient to them indicating that only adhoc meetings were held. This could be a result of a heavy work schedule

Item 37 : Number of traditional healers involved in the clinic programmes

Table 5.18. Number of traditional healers involved in the clinic programmes (N = 10)

No. of healers	Frequency
1 - 4	4
6 - 10	2
10 and above	4
Total	10

According to table 5.18, only 10 (37.0%) nurses gave the number of traditional healers involved in programmes. Their participation is a good start for collaboration. Traditional healers who are involved in the programmes could be encouraged to pass the information to other traditional healers.

Item 38 : Venue of programmes for traditional healers

Of the respondents, 10 (37.0%) nurses said the training programmes are usually held in the clinics. This is in line with the responses in item 37 where 37.0 percent of the nurses mentioned the number of traditional healers who attended the programme.

Item 39 : People involved in teaching

Of the respondents, 51.9 percent said that nurses were mainly involved in teaching in these programmes. In item 34 only 14.8 percent of the nurses said they have a programme for traditional healers. The contradiction is noted again in this response. It may be that some of the nurses gave their responses from previous experiences. It is not surprising that nurses implement the traditional healers' training programme as most of the clinics are manned by the nurses.

Item 40 : Other persons involved in the clinic programmes

According to item 39, 51.9 percent said that it was mainly nurses who are involved in the programme. However, in this item, the other people involved in the clinic programme were:

- doctors when they have time
- AIDS counsellors where available
- Health Inspectors where they are available.

This response indicates that health personnel where available work as a team. The main constraint was the absence of other health professionals in the clinics.

Item 41 : Cooperation between nurse practitioners and traditional healers that can benefit the community

The type of cooperation between traditional healers and nurse practitioners that was seen by nurse practitioners as being beneficial to communities were as follows:

- Developing trust between traditional healers and nurse practitioners.
- Planning for regular meetings by both groups to discuss common health problems.
- Establishing rapport and understanding between both health care providers.
- Referring patients from both groups that is, from traditional healers to nurse practitioners and vice versa.
- Holding workshops together to share experiences.
- Traditional healers accompanying their clients to health facilities when they are referred.
- Advising communities to feel free to consult any health worker when sick and disclosing the type of treatment given if referred to another facility.

The above responses show that there is a range of activities in which the traditional healers and nurse practitioners could cooperate and which could benefit the communities. The fact that nurses have named these activities is a symbol of commitment on their part and of an understanding that collaboration is essential for the benefit of the people served.

5.3 SUMMARY

In conclusion, one would say that according to this data collected from the nurse practitioners, nurse practitioners involve traditional healers in primary health care to a limited extent. For example 25.5 percent said they refer patients to traditional healers while 40.7 percent said they hold gatherings with traditional healers to share experiences and give traditional healers training. The observation is that there is no standardized procedure to follow. As a result, each nurse practitioner did what he/she thought was convenient to her/him in the clinic at the rate and time interval she determined.

As much as there was little support given to traditional healers by nurse practitioners, these nurse practitioners observed that traditional healers were an asset in the communities. The nurse practitioners noted that traditional healers could be effectively utilized in the prevention of common illnesses (88.9%), on education of communities on health issues (92.6%) and on home-based care on HIV/AIDS (85.2%). Other significant areas which were outlined were: they could be trained as AIDS counsellors and in encouraging the referral system from the communities to health facilities. These observations made by nurse practitioners suggest that traditional healers have room in primary health care activities if given support. The detailed conclusions and recommendations will be given in chapter six.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

The findings and interpretations of research investigation together with the major decisions that the researcher has made are communicated... through research reports. (Polit and Hungler 1993:51)

6.1 INTRODUCTION

This chapter gives a general discussion and interpretation of the findings on collaboration between traditional healers and nurse practitioners in primary health care in Maseru HSA in Lesotho.

The purpose of the study was to describe the existing relationship between traditional healers and nurse practitioners in Maseru Health Service Area in Lesotho and to determine why people sometimes choose to consult traditional healers when they are sick. The discussion of the findings is done in relation to the research questions which are answered in this study as well as the theoretical framework. The research questions were as follows:

- In what ways are traditional healers involved in primary health care at grassroots level?
- What are the support systems available to traditional healers in primary health care services?
- Why do clients at times choose to consult traditional healers and not modern practitioners?

- What are the views of traditional healers and nurse practitioners regarding their collaboration in primary health care?

The findings in this study relate to Maseru Health Service Area in Lesotho and are discussed under the research questions and the theoretical framework.

6.2 CONCLUSIONS

6.2.1 Involvement of traditional healers in Primary Health Care at grassroots level

The results of this study indicate that traditional healers are involved in primary health care to a limited extent. Even where nurses involved traditional healers in primary health care, the involvement was ad hoc and as a result there was no consistency. In Chapter 5, item 17, involvement of traditional healers included referral of patients to traditional healers and holding gatherings with traditional healers to discuss health issues.

In Chapter 5, item 17, only seven nurses said they refer patients to traditional healers and yet in Chapter 4, item 30, only three traditional healers indicated that they have treated patients with cancer, epilepsy, *litoromo* and *sejeso* referred by modern practitioners. This reveals that referral of patients to traditional healers is done by only a few nurses. In Chapter 5, item 28, nurse practitioners indicated that one of the reasons for failure to refer to traditional healers is the absence of the law which covers the nurses for such referrals. In Lesotho, the primary health care referral system begins with the Village Health Worker in the community referring patients to the clinic nurse and then the Health Service Area hospital (Community Reference Manual 1984:4).

This referral system does not make reference to traditional healers unless a traditional healer is also a Village Health Worker. This indicates that referral of patients to traditional healers is limited.

Another finding is that traditional healers do not refer patients to other traditional healers. In Chapter 4, item 15, 86.7 percent of the traditional healers said that they advise patients who do not respond to treatment to consult the nearest clinic. This suggests that traditional healers are not satisfied with the performance of other traditional healers. Msothi (1992:7) also notes that:

there is need to discuss closer cooperation between traditional healers and modern practitioners and amongst the traditional healers themselves. There is need for traditional healers to share knowledge and practices which may not be similar and may benefit the society.

In a workshop organized by the Psychiatric hospital in Maseru on 3rd February 1999, traditional healers recommended that modern practitioners should be encouraged to refer patients with problems related to customs, beliefs and traditions to traditional healers. Traditional healers therefore have a concern about failure of modern practitioners to refer patients to traditional healers. In Chapter 4, item 30, 24 traditional healers said that modern practitioners do not trust them and this is evidenced by the anger modern practitioners exhibit when patients consult them after these patients have been to traditional healers.

Pretorius (1991:11) notes that “in order for mutual referral to take place, it is important that both types of healers take part in some basic training to alternative type of care.” The training suggested by Pretorius (1991:11) will enable the health workers to refer patients to the alternative

type of care when appropriate. In addition, this process will enable practitioners to incorporate some of the useful ideas and practices employed by their counterparts, thus also improving their own practice (Pretorius 1991:11)

The issue of referral of patients by modern practitioners to traditional healers is sensitive and needs serious consideration. If referral is accepted legitimate, protocols will have to be developed to serve as a guide for referral between the two systems.

6.2.2 Holding gatherings with traditional healers

Most (70.4%) of the nurse respondents in Chapter 5, item 17, noted that they hold gatherings with traditional healers to discuss health issues such as involvement in PHC. What seems to be a weakness is that there is no standardized programme on how often the meetings should be held and which issues need to be discussed. For example, in Chapter 5, item 34, only 14.8 percent said they have a programme for traditional healers and in item 36 only 11.1 percent of nurse respondents said they offer the programme monthly. This is contrary to item 17 where 70.4 percent said they hold gatherings with traditional healers. This difference could be due to some nurses having contact with traditional healers on an ad hoc basis.

It seems individual clinics do what they deem necessary and convenient regarding the meetings. Consistency with the meetings is lacking. In Chapter 4, item 26, 4 traditional healers said they used to have meetings with nurses in the clinics, but the relationship stopped due to the lack of trust on the part of the nurse practitioners.

Despite the moderately low level of involvement of traditional healers in PHC, a high percentage

of nurses observe that traditional healers have a potential to contribute to PHC. For example, in Chapter 5, item 19, 88.9 percent of nurse practitioners said that traditional healers could be utilized in the prevention of common illnesses and 85.2 percent said traditional healers could be utilized as a support system in home-based care for AIDS patients. Landman (1994:211) notes that:

in support of the role of the families, traditional healers, tribal authority and care groups organized by nursing staff could play a major role in facilitating social support especially because these groups are willing to become involved

Involvement of traditional healers in the areas cited by the nurses requires community involvement in health care and in the establishment of a relationship between traditional healers and nurse practitioners. Prevention of common illnesses and home-based care for AIDS patients is a basic need in the communities for which they need support. Mahoko (1997:5) notes that health services do not meet the basic health care needs of the majority of people and that these services are therefore considered to be inadequate.

6.2.3 Support system available to traditional healers

In Chapter 5, item 24, only 33.3 percent of nurse respondents said they give support to traditional healers through training. There has been a global recognition that giving support and training to traditional healers can make them valuable resources in health care. For example, HST Update (1998:8) indicates that “in Uganda, THETA (Traditional and modern practitioners together against AIDS and other diseases) utilizes traditional healers as health educators, counsellors of STD’s and other diseases.” Traditional medicine in Uganda in HST Update (1998:12) further

notes that the reasons why traditional healers are valuable resources are:

- *as care providers, they vastly outnumber modern doctors in Uganda*
- *their work and responsibilities are self-sustaining.*
- *as an indigenous resource, deeply rooted in culture, they take a holistic approach and command a unique knowledge and respect to influence health improvement behaviour.*

As an influential resource in health, traditional healers can benefit from widespread training because their skills and knowledge can be enhanced, especially if the training is well-coordinated and well-planned. Through training, ideas can be shared and those ideas which are thought to be detrimental to health can be discouraged. Hoff and Maseko (1986:416) note that “in a project in Swaziland, joint training workshops demonstrated that traditional healers, when properly trained and given support, could assist in providing effective health care to the community.” Troskie (1997(a):29) also suggests that “the health system should encourage the training, use and support of community health workers as cost effective additional or alternative personnel.”

Another finding regarding support is that traditional healers do not consult other traditional healers when sick. In Chapter 4, item 18, 93.3 percent of traditional healers noted that they consult modern practitioners when sick. This further underscores the lack of support and trust amongst the traditional healers themselves. This finding confirms the notion that traditional healers would rather consult modern practitioners than another traditional healer when in need of care.

6.2.4 Why do people consult traditional healers?

In Chapter 5, item 21, 81.5 percent of nurse practitioners indicated that people consult traditional healers because traditional healers can give the cause of disease, because people think they have been bewitched, and because people trust traditional healers. In Chapter 4, item 16, traditional healers said that people consult traditional healers for almost similar reasons mentioned by nurse practitioners, with the addition of failure of modern practice to cure certain diseases given as a reason.

The reasons given above, suggest that traditional healers have a significant contribution to make to health care. The fact that people trust them and consult them when sick is an indication that at some stage during the life cycle, people must have benefitted from the consultations. Meines (1998:12) confirms these finding by noting that:

patients seek alternative medicine for a variety of reasons, including ethnic and folk practices, cult involvement, disillusionment with mainstream medical practices, the growing rebellion against technology and perceived impersonalization of medical care.

Hess (1998:6) also observed that “traditional healers are the first contact and front-line service provider of health services and they also help by referring patients to modern practitioners.” In Chapter 4, item 15, 86.7 percent of traditional healers said they advise patients who do not respond to treatment to consult the nearest clinic. That traditional healers would advise patients to consult modern practitioners suggests that traditional healers value the abilities of modern practitioners, and this could also indicate the readiness of traditional healers to cooperate with

modern practitioners. It is a commendable idea for traditional healers to refer patients to modern practitioners. Collaboration with traditional healers is necessary because traditional healers are a strong force in the health sector and are here to stay (Jones 1998:1057).

Consultation of traditional healers is not limited to the rural population only. It has been observed that the elite also consult traditional healers when they have health problems. For example in Troskie (1997(a):31), “a study at WITS indicated that 80 percent of the black community visited a traditional healer before consulting other health services.” De Jong (1991:6) also noted that “a survey conducted in Ibadan in Nigeria, found that roughly 70 percent of both highly educated and the less privileged members of the community used traditional healers.”

The findings on why people consult traditional healers confirm that Basotho people around Maseru Health Service Area are still traditional in their values. For example, they still believe in the traditional causes of disease such as being bewitched or somebody causing a misfortune to befall them. These cultural values determine the choice of the practitioner when sick and the response to illness.

6.2.5 Collaboration between traditional healers and nurse practitioners

Cahill and Palmer (1989:30) advocate that “for the health care delivery system to function at an optimal level, nurses will be required to develop closer partnerships with other health workers and with their patients.” Collaboration between traditional and modern practitioners is therefore viewed as between the two health systems.

The research findings indicate that there is no formal collaboration between traditional healers and nurse practitioners. Perhaps this is also what accounts for the lack of information on how many traditional healers are available in Maseru Health Service Area. If formal collaboration existed, each clinic would know how many traditional healers there are in their service area.

In Chapter 4, item 23, 96.7 percent of traditional healers felt that collaboration with nurse practitioners was essential and this should include referral of patients to traditional healers and allocation of a corner at a health facility where traditional healers can operate to ease referrals. Traditional healers are already referring patients to modern practitioners, evidenced by the response in Chapter 4, item 15, where 86.7 percent of traditional healers said they advise patients who do not respond to treatment to consult the nearest clinic.

The type of collaboration suggested in the above paragraph is confirmed by the recommendation from the traditional healers in a workshop organized by the Psychiatric hospital in Maseru on the 3rd February 1999. The traditional healers reiterated that modern practitioners should refer patients to traditional healers. The following structure for collaboration was suggested.

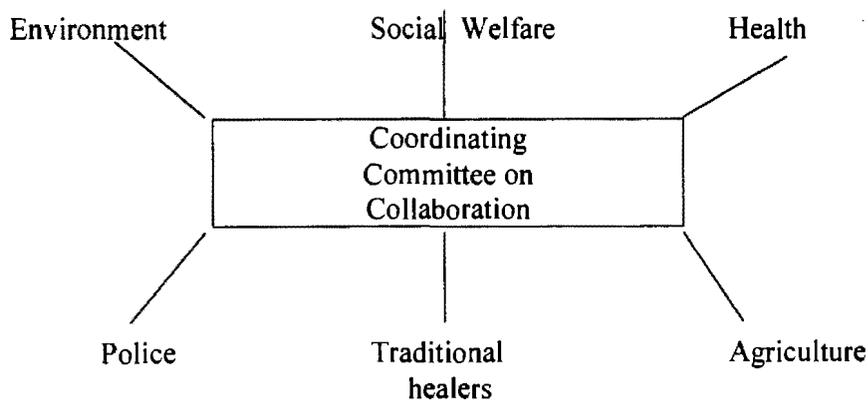


Figure 6.1 Suggested Structure for Collaboration between traditional healers and nurse practitioners

The sectors reflected in figure 6.1 are not the sole sectors required for collaboration, but were identified by the participants in the workshop because it was agreed that these sectors play a critical role in either preventing mental health problems or assisting an individual who has a mental health problem. If intersectoral collaboration can be achieved as suggested, communities can benefit from the improvement of health care services. Ramduny (1998:5) notes that “intersectoral collaboration is about different sectors working together in order to achieve a certain developmental goal. Such a goal is usually orientated towards the eradication of poverty and an improvement in the quality of life of the people”.

6.2.5.1 Benefits from collaboration

Editorial (1997:135) in public health nursing notes that:

Community-based services are built on collaboration and partnerships between community leaders, consumers and providers. When community people are involved as partners, community-based services are thought to be responsive to locally defined needs, are better utilized and are sustained through local action.

Traditional healers are a local resource and respond to local needs because they are members of the community and they are knowledgeable about the culture of the people. Some of the benefits of collaboration identified were:

- *patients benefit directly when they get better after they have been treated by both groups.*
- *experiences and skills are shared through exchange of information.*

- *cooperation helps traditional healers and nurse practitioners to know each other and their ways of treating diseases.*

Cooperation will build trust thus getting rid of the hostilities that traditional healers complain of. For example, in Chapter 4, item 30, traditional healers argued that modern practitioners do not trust them and become angry with patients who have been to traditional healers.

Van der Linde (1997:268) also argues that western medicine and traditional African medicine:

have always sat together uncomfortably, each dismissing the other with suspicion yet treating the same patient. The patient has to put up with this alienation as traditional healers refuse to acknowledge that they do not always know how to treat certain diseases for fear they will lose face with the patients while western medicine does not always have cures for illnesses that stem from traditional cultures and beliefs.

6.3 DISEASES WHICH TRADITIONAL HEALERS CAN TREAT EFFECTIVELY

In Chapter 5, item 23, 55.6 percent of nurse respondents said that other conditions which could be treated by traditional healers effectively include cancer, traditional medicine given during pregnancy (pitsa), upper respiratory tract infections, conditions resulting as a result of cultural beliefs, infertility and mental illness. These responses reveal that nurses recognize that traditional healers have certain abilities to cure some conditions. Leininger (1984:72) notes that “nurses are increasingly aware that cultural factors are important in the prevention of illness, in recovery, and in the maintenance of a healthy life style.”

The recognition of the abilities of traditional healers is also indicative in the number of patients who continue to consult traditional healers when they are sick. This is evidence that they get some relief from traditional healers' treatment. Crawford (1995:292) also notes that "traditional healers in Kwazulu Natal have particularly impressive skills in the area of marital relationship problems ... Close collaboration in Hlabisa has enabled patients to live with traditional healers while receiving medication."

The responses from nurse practitioners and the literature cited from Crawford (1995:292) suggest that traditional healers have knowledge, skills and experiences in dealing with certain diseases. Collaboration with nurse practitioners can enhance the skills of traditional healers and nurse practitioners and can enable the two groups to share knowledge for the good of the communities served. West (1993:229) also argues that "the answer to a peaceful coexistence and a more positive cultural exchange lies in two groups bridging their beliefs and values while retaining their individuality."

6.4 HOW TRADITIONAL HEALERS CAN BE UTILIZED EFFECTIVELY IN PHC

In Chapter 5, item 19, 88.9 percent of nurse practitioners indicated that traditional healers could be utilized in the prevention of common illnesses. Some of the strategies in the prevention of common illness could be to engage them in motivating parents to bring their children for immunizations. Traditional healers could also be engaged in motivating people to use condoms and also distribute them in the struggle to prevent AIDS.

That nurse practitioners can name areas which traditional healers and nurse practitioners can

collaborate signifies the willingness on their part to collaborate with traditional healers. The nurses are aware that traditional healers can be a major source of support in the health care system. Boehnlein (1990:37) notes that “traditional and scientific healing can coexist so long as they maintain their common goal of returning the patient to health.”

6.5 CONTRIBUTIONS THAT TRADITIONAL HEALERS CAN MAKE TO PHC

In chapter 4, item 31, traditional healers indicated that by virtue of their activities, they are already involved in PHC. Their activities include curative and preventive measures as well as participation in resolving social problems. These responses indicate that traditional healers understand what PHC is and the activities involved in it. What is essential is to strengthen their skills and to support them so that they do not feel alienated.

Only two traditional healers felt that they would need some guidance if they are to be formally involved in PHC. It is encouraging to observe that some traditional healers can accept their inadequacies and are willing to be guided in PHC activities. This further underscores the willingness of some traditional healers to work together and to be trained by modern practitioners.

Nurse practitioners can therefore take the opportunity to educate traditional healers on PHC activities in order to promote the health of communities. Craffet (1997:5) notes that

in view of collaboration, not only biomedical models prove inadequate, but the same applies to traditional health care systems... The medical systems of most societies possess numerous types of disease, each requiring specific remedial measures. They all lack

the comprehensiveness required in an integrated approach.

6.6 THE FINDINGS OF THE STUDY AS APPLIED TO LEININGER'S THEORY

According to Leininger in Fitzpatrick and Whall (1996:185), nursing is “essentially a transcultural care phenomenon and lived experience, the uniqueness of which centres on providing human care to people in a way that is meaningful, congruent, and respectful of cultural values and lifestyles.” If nurses, therefore, want to deliver care that is congruent and respectful to the culture of the people of Lesotho, they will have to determine ways to include the traditional healers in the provision of primary health care. According to the findings of this study, there is a clear indication that nurses are willing to participate in setting structures to achieve cooperation with the traditional healers.

Culturally congruent care can, however, not be achieved through superficial knowledge and limited contact with a cultural group. The “social structure, world view, cultural values, language, and environmental contexts, as depicted in the sunrise model” should be examined (Leininger in Fitzpatrick & Whall 1996:185). In recognizing and respecting the cultural values of the people, congruency will be achieved and imposition of cultural beliefs, conflicts and negligence of cultures can be prevented. As the nurses in this study are all from the same cultural background as the traditional healers and the community, this should not be difficult to achieve. In Chapter 5, item 19, 88:9 percent of nurses indicated that traditional healers could be utilized in AIDS counselling and in the prevention of common illnesses. Utilizing traditional healers in primary health care activities can ensure that harmless values, beliefs and customs are incorporated in counselling and in the prevention of common diseases. Support that comes from

people who observe and respect traditional beliefs and customs such as traditional healers is likely to have a positive impact on the health of the people. Counselling and other activities to prevent common diseases requires traditional healers to work very closely with nurse practitioners. These nurses should also be strengthening their skills regarding alternative care and the use of traditional beliefs and customs in primary health care in order to provide culturally congruent care to the people.

The following three major modes guide judgements, decisions or actions for providing culturally congruent care. Their significance to collaboration between traditional healers and nurse practitioners in health care in Lesotho is discussed in the following sections:

- *Cultural care preservation or maintenance*
- *Cultural care accommodation or negotiation*
- *Cultural care repatterning or restructuring*

6.6.1 Cultural care preservation or maintenance

In order to enhance collaboration between traditional healers and nurse practitioners in Lesotho, nurses will have to assist and support communities to retain and preserve relevant care values. This will ensure that the well being of the people will be maintained, that people will be able to recover from illness and will be able to face handicaps and or death (Fitzpatrick & Whall 1996:1850). In this study, one of the findings that indicated supportive actions is that, during the training period of an initiate who is often sick, a traditional healer trainer often lives with the trainee in the trainer's home in order to monitor the initiate closely. This is demonstration of caring for the initiate on the part of the trainer. These cultural care values could be preserved and

maintained. During collaboration between traditional healers and nurse practitioners, these cultural values will need reinforcement because they are assistive and supportive to the individual to enable him/her to recover or cope with illness.

6.6.2 Cultural care accommodation or negotiation

To assist people of a specific culture to adapt to, or negotiate with others to ensure beneficial or satisfying health outcomes, certain creative, supportive, assistive and facilitative actions or decisions are necessary (Fitzpatrick & Whall 1996:185). The findings in this study reveal a lack of trust between traditional healers and nurse practitioners. Traditional healers feel that modern practitioners do not trust them and despise their efforts in treating people. Cooperation between the two health care providers will lead to understanding and accommodating each others values and this will result in building trust. Trust between the two groups will lead to supportive behaviour towards each other which can lead to a beneficial or satisfying health outcome.

6.6.3 Cultural care repatterning or restructuring

Traditional healers should be assisted to change, modify and reorder their lifestyles, to accept new, different and beneficial health care patterns. To achieve this, the cultural values and beliefs of the people served should be taken into account, but at the same time, they should be given guidance on how to adapt to the new order (Fitzpatrick & Whall 1996:185). Cooperation between traditional healers and nurse practitioners will mean that the two groups have to accommodate each other's values regarding care. Nurses will have to negotiate with traditional healers to give up harmful practices such as treating diarrhoea with enema (Green 1988:1127). In

Chapter 5, item 17.2, 70.4 percent of nurses said they hold gatherings with traditional healers to discuss health issues. This is an opportunity for nurses to negotiate with traditional healers on the use of oral rehydration solution in order to achieve a satisfying health outcome. This suggests that traditional healers will have to modify their lifestyles and their practices with the guidance and support of nurse practitioners.

It must be noted therefore, that to implement these objectives, cooperation is necessary between the nurse, traditional healer and the community. Leininger in Fitzpatrick & Whall (1996:188) also distinguishes between the concept generic care (folk care) and professional nursing care. Generic or folk care refers to “culturally learned and transmitted lay, indigenous (traditional) or folk knowledge and skills used to provide assistive, supportive, enabling, facilitative acts (or phenomena) towards or for another individual, group or institution with evident or anticipated needs to ameliorate or improve a human health condition (or well being, disability, life way, or to face death)”.

In this study, traditional healers have revealed that their activities do not just begin and end with prevention of illness and cure. Their roles also include mediation in social problems. For example, they have the capability to protect property against theft, to keep families together by ensuring that a man does not see other women and to prevent hail storm that destroys crops.

Traditional healers have played a major role in assisting and supporting individuals, families and groups to lead healthy less stressful lives. Cooperation with nurse practitioners in health care can lead to nurse practitioners and to traditional healers supporting each other especially with mediation in social issues as this can be viewed as a form of counselling for traditional healers.

According to Leininger in Fitzpatrick & Whall (1996:188) professional nursing care on the other hand refers to:

formal and cognitively learned professional care knowledge and practice skills obtained through educational institutions that are used to provide assistive, supportive, enabling or facilitative acts to or for another individual or group in order to improve a human health condition (or well being, disability, life way, or work with dying clients).

Nurses in Lesotho work in the clinics, they are nearer to the people than other health professionals. Their roles often include training community health workers, providing direct care and providing health information to the communities. These roles have certainly prepared the nurses for working with other people and therefore, collaboration with traditional healers will not be an alien concept. WHO (1984:17) notes the important roles that nurses play at community level.

At the peripheral level, nursing personnel are often involved in providing direct care to the community, either on an individual basis or as members of teams. Generally, their roles include arousing the interest of the community in the benefit of a positive health approach. In meeting the health needs of the community, they are often involved in training community health workers and also in extending and improving the knowledge and skills of traditional health practitioners.

The model shown in figure 6.2 serves as a guide to suggest how collaboration between traditional healers and modern practitioners can be done. The area of cooperation incorporates cultural care preservation/maintenance, cultural care accommodation/negotiation and cultural care repatterning/restructuring as depicted in the sunrise model (Leininger in Fitzpatrick & Whall 1996:185).

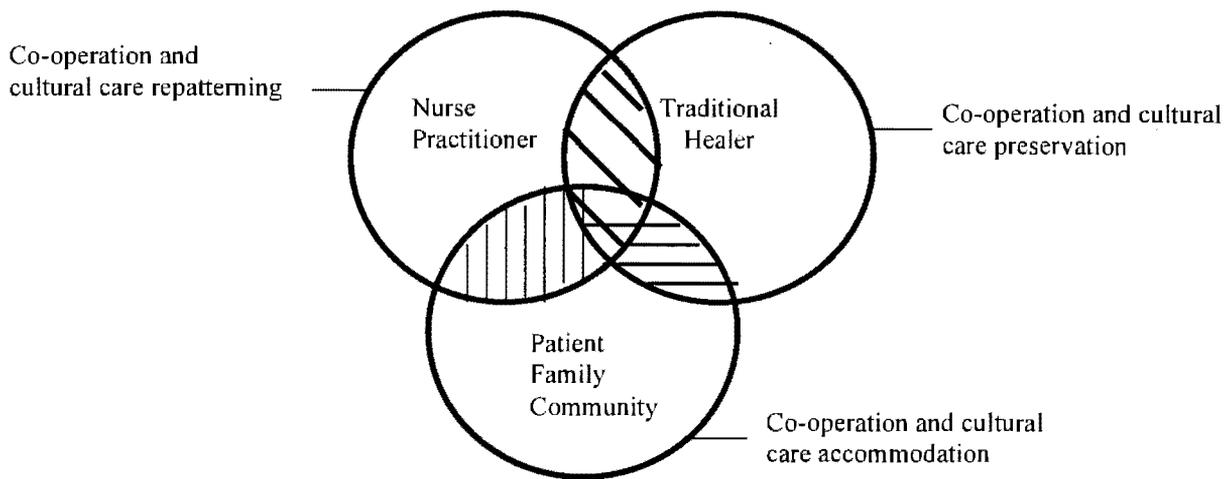


Figure 6.2 Model indicating collaboration between traditional healers and nurse practitioners

This model (figure 6.2) suggests that nurse practitioners and traditional healers if collaborating, can form a team to support each other in health care. Clients are included in the model as part of the team because they utilize the services of both groups. Support can be in many forms such as negotiating amongst all three groups to do away with harmful practices, retaining and preserving harmless and useful beliefs and sharing information through training to ensure cultural repatterning/restructuring.

Collaboration should, however, be approached with the necessary understanding of the culture of the Lesotho people, giving credit to those practices and treatment that do have medicinal value. If not, the following quotation by Kriel (1989:209-210) could become a reality:

The parting of ways between African and modern medical ideas lie very deep: very near to man's experience with plants and other substances. Once the traditional African has decided that similarity forms a basis for arguing towards causality, and the man in the white coat insists that causality should first be proved experimentally before any further deductions can be made, what possibility is there of reconciling them?

On the other hand,

It is hoped that the insights obtained from this study will also have a sobering effect on inpatient outsiders who have dealings with Africans. Let them consider that the ancient tradition, whatever the futility of constructing a future on them, did indeed afford deep emotional security. And let them consider what they themselves are offering Africa: whether it is a unified system or a fragmentary jumble of often contradictory values." (Kriel 1989:211)

6.7 CONTRIBUTIONS OF THE STUDY TO NURSING

In Lesotho, nurses are the only health professionals found in the clinics, especially in the remote areas. One of the responsibilities of these nurses is to solve health problems in the areas where they are located. Horner, Ambroque, Coleman, Hanson, Hodnicki, Lopez and Talmadge (1994:145) also note that "the health care of rural people is of major concern to nursing as nurses are frequently the only local health care providers in many rural areas." Meines (1998:14) also indicate that "nurses, in many cases are the closest to the patients and are the patients' strongest advocate and educator."

- Nurses by virtue of their location in clinics are nearer to the communities and they are therefore in a better position than other health professionals to negotiate with the traditional healers on collaboration between nurse practitioners and traditional healers for a satisfying outcome.
- Collaboration between traditional healers and nurse practitioners can lead to openness in both groups so that each can learn from each other. Traditional healers are sometimes referred to as being secretive. For example Troskie (1997(a):34) noted that "some

traditional healers are unwilling to disclose their knowledge because they believe that they can lose their power to heal.”

Pearce (1989:922) observes that

the problem of secrecy deserves some attention. Western education holds openness ... The communal ownership of knowledge as well as free and open communication is said to be required for the testing of knowledge claims and the growth of information.

Quaye (1996:43) also observes that “Governments’ support and recognition of the important role of traditional medical practices will go a long way towards removing the secretive and unhygienic labels associated with the traditional medical practice.”

Though secrecy is a weakness on the part of traditional healers, modern practitioners are also noted for their reluctance to involve people in their own care. For example, Leininger (1984(a):42) notes that:

Many nurses believed that whatever they had to offer to their clients was a professional gift and would surely be accepted without question. After all, nurses knew what was best for their clients, and clients were expected to follow their wishes.

Evian (1989:36) also notes that the “medical profession are extremely reluctant to let go of their hold on the provision of basic medical care and are guarding their territory very carefully.”

- Nurse practitioners and traditional healers collaborating in PHC can do a lot of preventive work against harmful practices through established links between groups. Health problems can be solved together. In Chapter 5, item 19, 88.9 percent of nurse

practitioners said that traditional healers could be utilized to prevent common illness.

- Payment in health institutions is in cash. In Lesotho, health services are subsidized, evidenced by the fact that an adult pays M10.00 for consultation including medication in Government institutions. People in Lesotho are poor and cash is not always available. Traditional healers sometimes are paid only when cash is available or paid with any available resource such as agricultural produce. This suggests that consumers in the rural areas need to be given consideration because of the lack of cash to pay for health care.
- Modern medicine will benefit when demands on its meagre human resources especially the nursing resource are relieved by cooperating with traditional healers because in a way human resource will be shared.
- For collaboration to be effective, training of both traditional healers and nurse practitioners is essential. Troskie (1997(b):41) in support of training, notes that “nursing staff should be responsible for coordinating the programmes and should ensure that the needs of the communities and the service are met.” The skills of both nurses and traditional healers will be enhanced through training.

6.8 PROBLEMS FACED BY TRADITIONAL HEALERS IN HEALTH SERVICE DELIVERY

- Traditional healers observe that amongst themselves, there are some traditional healers who lack knowledge and skills to practise their profession. These traditional healers are

giving traditional practises a bad image.

- Traditional healers lack facilities where they can practise their profession properly. It is for this reason that they request modern practitioners to assign them a corner in a health facility where they can practice.
- Traditional healers feel that modern practitioners do not trust them. This accounts for the anger which modern practitioners show when they are consulted by patients who have been to traditional healers. In Chapter 4, item 30, traditional healers indicated that modern practitioners feel that patients would rather die than refer them to traditional healers.
- Traditional healers do not support each other. The results in this study indicate that traditional healers do not consult other traditional healers when sick and do not refer patients to other traditional healers. This finding suggests that traditional healers do not support each other.

6.9 PROBLEMS FACING NURSE PRACTITIONERS IN PHC

- Nurse practitioners are overwhelmed by the amount of work they have to deal with in the clinics because in most clinics, there is only one registered nurse and a nursing assistant. In Chapter 5, item 10, 11(eleven) clinics said they each have 1 (one) registered nurse. The Lesotho health sector reform document of the Ministry of Health (1st draft) (1999:20) alludes to the chronic shortage of health personnel. According to this document, the

chronic shortage is due to inadequate facilities and staff at National Health Training College (NHTC) for the number of personnel who need training.

- Some nurse practitioners are concerned with the approach of some traditional healers to certain diseases. For example, in Chapter 5, item 22, 85.2 percent of nurse practitioners said traditional healers could not treat diarrhoea effectively because they give a laxative which causes more fluid loss thus leading to dehydration and sometimes death.
- Nurse practitioners lack clear policy guidelines by the Ministry of Health regarding collaboration with traditional healers. In Chapter 5, item 28, nurse practitioners said they do not refer patients to traditional healers because there is no law that protects them.

6.10 THE WAY FORWARD

WHO (1996:11) indicates that strategies for the way forward include answering the following questions:

What do we want?

What do we have?

What do we need?

What can we afford?

These questions are discussed below in relation to collaboration between traditional healers and nurse practitioners in PHC.

What do we want?

Lesotho is a mountainous country and this makes travel and communication difficult. Health service coverage within affordable reach is required. Collaboration between traditional healers and nurse practitioners can answer part of this requirement.

What do we have?

Lesotho's traditional healers have the cultural background to deliver basic health services to its communities. If given the opportunity, and given proper training, traditional healers can reduce the burden of disease and contribute to the well being of the communities.

What do we need?

Lesotho needs to deliver health care services utilizing a multi-sectoral approach. Multi-sectoral approaches encompass all the departments including that of traditional healers. The suggested multi sectoral approach is shown in figure 6.1.

What can we afford?

Lesotho affords local people with knowledge of beliefs and customs that can be incorporated into the care of people. Traditional healers have this knowledge.

WHO (1996:10) further notes that “most countries are currently talking of health reforms which need to improve access, quality, coverage and cost-effectiveness in the delivery of health care.” Cooperation with traditional healers, if well-planned, can form part of the solution for health reforms, especially given the shortage of personnel and problems related to accessibility of health facilities due to topography of the country.

6.10.1 Recommendations

- The Ministry of Health and social welfare needs to reconsider the initial strategy for staffing the clinics. When PHC was first conceptualized, the clinics were supposed to be manned by 1 (one) nurse clinician, 1 (one) registered nurse and a nursing assistant. Improved staffing patterns can accommodate support and training of traditional healers in PHC activities.
- Lesotho Universal Medicine Men and Herbalist Council needs to be strengthened and supported by the Government and by traditional healers in order for this office to be able to identify and deal with charlatans who claim knowledge without a training background.
- The Ministry of Health should cooperate with other Ministries, CHAL and non-governmental organizations to develop policy guidelines on collaboration between traditional healers and nurse practitioners in order to ease the referral system, create training and other systems of support.
- An intersectoral workshop on alternative health care should be held for all interested parties and health care providers in preparation for the official collaboration between traditional healers and nurse practitioners in PHC.
- A standardized training programme for traditional healers should be planned. This will support agreements in which areas traditional healers can participate during collaboration in PHC. The training programme should include:

- distribution of oral rehydration solution (ORS) packets especially to children with diarrhoea.
- distribution of condoms and motivation of people to use condoms
- basic training on home-based care, counselling and support for AIDS and other critically ill patients. According to Maw (1998:12), in 1998, there were 3,242 reported AIDS cases in Lesotho while the statistics of reported cases in this country in the previous three years was as follows:
 - 1995 – 341 AIDS cases
 - 1996 – 936 AIDS cases
 - 1997 – 2203. AIDS cases (Maw 1998:12).

This suggests that AIDS is on the increase in Lesotho and assistance from other sectors to deal with prevailing health problems and support of health personnel is required.

- motivation of mothers and fathers to take their children for immunization as a strategy to prevent illnesses as suggested in Chapter 5, item 19.
- identification of TB patients and referral of those suspected to have TB to the nearby clinic. Follow up of these patients will help to ensure that patients adhere to the required drug regimen. According to Ntšekhe et al, (1997:3) Maseru

Health Service Area has the highest TB rate in the country at 720/100,000 population. A concerted effort is needed to prevent the spread of TB and to follow up those already affected.

Nurse practitioners can spearhead this training because of their proximity to the communities who live near the clinics. Swanson and Anies (1997:199) also note that:

*Nurses are agents of change in their advocacy role
nurses are seen as professionals whose knowledge,
skill and concern are used to promote society's well
being through a disciplined change process.*

6.10.2 Limitation to the Study

Limitation related to sample

The target population for nurse practitioners was small due to the defined study area.

Due to the difficulty of identifying traditional healers within the defined study area, the target population for traditional healers was also small.

Limitation related to data collection

The geographical situation of the country made travelling to remote areas difficult especially during rainy days because roads were slippery.

Data was collected when Lesotho experienced major political upheaval and travel was difficult

because of insecurity in the country. This was a difficult period when nobody trusted anybody and this had an impact on the participants.

Some interviews were done at the clinics. The clinic environment was likely to influence the traditional healers in their responses. This environment did not give the researcher an opportunity to make observations regarding the consulting rooms at their homes.

6.10.3 Further Research

Another study on collaboration between traditional healers and modern practitioners is essential. Such a study should cover the ten (10) districts in Lesotho to enable generalization of the findings. The suggested areas for study include:

- Unveiling the secrecy which surrounds traditional medicine.

Traditional medicine is noted for being secretive; removing the secrecy can lead to openness, thus enabling sharing of information by all health care providers.

- Understanding the role of cultural values in disease prevention, treatment and health promotion.
- Removing the guilt that people often experience when they have consulted traditional healers, can be a goal in the study.

Continued research will lead to nurses ultimately accepting traditional medicine as an alternative care that people utilize. Nurses therefore, will not blame anybody who has consulted a traditional

healer prior to visiting a health facility for treatment. Nurses are observed to express anger and hostility to patients who utilize the services of traditional healers.

Research in Lesotho on traditional healing will help nurses to understand the role of cultural values in disease prevention, treatment and health promotion. The understanding of cultural values will assist nurses to come up with a health system that can utilize the strengths of both traditional healers and modern practitioners for the good of the communities.

- finding the views of community members regarding collaboration between traditional healers and modern practitioners.

The community members are the consumers of health services. These consumers know what is best for them and their contributions regarding collaboration between traditional healers and modern practitioners is essential.

6.11 CONCLUSION

Collaboration between traditional healers and nurse practitioners has shown to be a problem due to the lack of trust between the two systems and also due to the lack of clear policy guidelines on collaboration.

Both traditional healers and nurse practitioners observe that collaboration is a need between the two systems. Nurse practitioners have identified areas which they think traditional healers can participate in, in order to solve the prevailing health problems.

With the recommendations made in this study, it is anticipated that traditional healers and nurse practitioners working together as a team can solve many common health problems. Public Health Nursing editorial (1997:135) notes that “the whistle has blown and the race is on, therefore, there is need to get ready for dynamic changes in the health care system.” The dynamic change can also be interpreted as collaboration between traditional healers and nurse practitioners in primary health care.

Together the best can be achieved.

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ANNEXURE A
INTERVIEW SCHEDULE FOR
TRADITIONAL HEALERS

Interview Schedule for Traditional Healers

--	--

QUESTIONNAIRE NO.

1- 2

SECTION 1 : BIOGRAPHICAL DATA

1. Sex:

M

1
2

F

3

2. Age:

0 - 19 years

1
2
3

20- 39 years

60 and above

4

3. Religion

Catholic

1
2
3
4
5

Anglican

L.E.C.

Apostolic

Other (Specify)

5

4. Marital Status

Married

1
2
3
4

Widowed

Single

Divorced

6

5. Educational Background

Never at school

1

Class 1-7

2

Junior Certificate

3

Cambridge Overseas

4

Other

5

7

6. In which residential area do you live?

Urban

1

Periurban

2

Rural

3

8

SECTION 2: HEALING PRACTICE

7. What type of a healer are you?

Sangoma

1

Herbalist

2

Spiritual Healer

3

Other (specify)

4

9

8. For how long have you been a healer?

0 - 5 years

1

6 - 10 years

2

11-15 years

3

16-20 years

4

21 - and above

5

10

9. Before you can practise as a healer, how long should you undergo training?

6 months

1

12 months

2

18 months

3

24 months

4

11

10. How much are you expected to pay for training to become a healer?

M50 - M500

1

M501 - M1000

2

M1001- and above

3

Other (Specify)

4

12

11. What influence have your traditional beliefs had on your becoming a healer?

.....

.....

.....

12. In your healing practice, do you work alone or with other people?

Alone

1

With other people

2

13

13. Explain why (any person chosen response) in 12.

.....

.....

.....

14. When a client consults you do you treat him alone or with the family?

Alone

1

With the family

2

14

15. What advice do you give to clients who cannot respond to treatment?

.....

.....

.....

16. In your opinion, why do people consult

Traditional healer?

.....

.....

.....

Modern healer?

.....

.....

.....

17. For which conditions do most of your clients consult you?

AIDS

1

Gastro-Enteritis

2

Tuberculosis

3

Epilepsy

4

Other (specify)

5

15

.....
.....
18. When you are sick which practitioner do you consult?

Modern Practitioner

1

Traditional Practitioner

2

16

19. Give reasons for your choice in 18.

.....
.....

20. Explain how you train a person to become a healer?

.....
.....
.....

21. How much do you charge a person for training?

M50 - M500

1

M501 -M1000

2

M1001 - and above

3

Not applicable

4

17

22. How much do you charge a person for consultation?

M5.00 - M50

1

M51.00 - M100

2

M101 - M150

3

M150 and above

4

Other (specify)

18

**SECTION 3: COLLABORATION WITH MODERN PRACTITIONERS
IN PRIMARY HEALTH CARE**

23. How would you like to collaborate with modern practitioners if possible?

.....

.....

.....

24. How would you like to collaborate with modern practitioners in

Prevention of Diarrhoea

.....

.....

AIDS

.....

.....

Tuberculosis

.....

.....

25. Which conditions do you think you can treat successfully?

	YES	NO	
Gastro-Enteritis	1	2	19
Tuberculosis	1	2	20
AIDS	1	2	21
Epilepsy	1	2	22
Other (specify)	1	2	23

26. What type of cooperation do you currently have with modern practitioners in primary health care?

.....

27. What benefit do you get from this cooperation?

.....

28. What benefit do you think modern practitioners get from this cooperation?

.....

29. Which type of patients do you refer to modern practitioners?

	YES	NO	
Gastro-Enteritis	1	2	24
Diabetes Mellitus	1	2	25
Hypertension	1	2	26
Others (specify)	1	2	27

30. What type of patients do you treat referred to you by modern practitioners?

	YES	NO	
Epilepsy	1	2	28
AIDS	1	2	29
Tuberculosis	1	2	30
Hypertension	1	2	31
Other specify	1	2	32

.....

.....

31. In your opinion, how can you effectively contribute to Primary Health Care?

.....

ANNEXURE B
INTERVIEW SCHEDULE FOR
TRADITIONAL HEALERS TRANSLATED
INTO SESOTHO

LIPOTSO TSA LINGAKA TSA MEETLO

--	--

KAROLO EA PELE

1 - 2

1. Boleng: Botona

1

3

Botseali

2

2. Lilemo: 0 - 19

1

4

20 - 39

2

40 - 59

3

60 le ho feta

4

3. Tumelo Moroma

1

5

Mochache

2

Mofora

3

Mopostola

4

E 'ngoe feela

5

4. Maemo lenyalong:

Ke nyetsoe

1

6

Mohlolohali

2

Ha kea nyaloa

3

Ke lahlane le molekane

4

5. Thuto Ha kea kena sekolo

1

7

Ke balile 1 - 7

2

Ke na le J.C.

3

Ke na le Matric

4

Ho hong feela

5

6. U phela kae? Toropong

Pela toropo

Mahaeng/metseng

1
2
3

8

KAROLO EA BOBELI: TSA HO PHEKOLA

7. U ngaka e fe ho ba latelang?

Mokoma

Ngaka-chitja

Thapelo

Ho hong feela

1
2
3
4

9

8. Ke nako e kae u folisa?

0 - 5

6 - 10

11 - 15

16 - 20

21 le ho feta

1
2
3
4
5

10

9. Pele u ka folisa, u ithuta nako e kae?

Likhoeli tse 6

“ ” 12

“ ” 18

“ ” 24

1
2
3
4

11

10. U lebeletsoe ho lefa bokae ho ithuta ho folisa?

M50 - M500

M501 - M1000

M1001 le ho feta

Ho hong feela

1
2
3
4

12

11. Litumelo tse hau tsa meetlo li bile le tsutsumetso e kae bakeng sa hau sa ho ba ngaka?

.....

.....

12. Tsebetsong ea hau ea ho phekola u sebetsa u le mong kapa u sebetsa le batho ba bang?

Ke le mong

Le batho ba bang

1
2

13

13. Fana ka tihaloso ea hore na hobaneng karabong ea hau ho No.12?

.....

.....

14. Ha u phekola motho u phekola eena feela kapa u kenyeletsa lelapa la hae tsebetsong eo?

A le mong

Le lelapa

1
2

14

15. Ho bakuli ba hau ba sitoang ho hlahoheloa u fana ka likeletso life?

.....

.....

16. U nahana hore batho ba ea lingakeng tse latelang ha ho le joang/hobaneng?

- Ngaka ea meetlo

.....

- Ngaka ea sekhoaa

.....

17. Bakuli ba hau ba bangata ke ba lefu lefeng?

Koatsi ea bosolla tlhapi

1

15

Letsollo le lehlato

2

Lefuba

3

Ho akheha

4

Le leng feela

5

18. Uena ha u kula u ea ngakeng efe?

- Ngaka ea sekhoaa

1

16

- Ngaka ea meetlo

2

19. Fana ka mabaka a karabo ea hau ho No. 18.

.....

.....

20. A k'u hlalose hore na u rupela batho joang hore e tle e be lingaka tsa meetlo?

.....

.....

21. U lefisa batho bokae ho ba rupela ka tsa bongaka?

M50 - M500

M501 - M1000

M1001 le ho feta

Ha ke lefise

1
2
3
4

17

22. Ho tla ngakeng ho uena ke bokae?

M5.00 - M50.00

M51.00 - M100.00

M101.00 - M150.00

M151.00 le ho feta

Ho hong.

1
2
3
4
5

18

KAROLO EA BORARO:

**TSEBELISANO 'MOHO LIPAKENG TSA LINGAKA TSA MEETLO
LE LINGAKA TSA SEKHOOA**

23. U ka rata ho sebelisana joang le lingaka tsa sekhooba ha eba ho hlokahala?

.....

.....

24. U ka rata ho sebelisana joang le lingaka tsa sekhooba mafung a latelang?

Thibelo ea letsollo?

.....

Phekolo le thibelo ea koatsi ea bosolla tlhapi

.....

Phekolo le thibelo ea lefuba

25. Ke mafu a feng ao u ka a folisang?

	YES	NO	
Letsollo	1	2	19
Lefuba	1	2	20
Koatsi ea bosolla tlhapi	1	2	21
Ho akheha	1	2	22
A mang (hlalosa)	1	2	23

26. Ha hajoale u sebelisana joang le lingaka tsa sekhoaa bakeng sa bophelo bo botle?

.....

.....

27. U fumana molemo o fe ka tsebelisano 'moho eo?

.....

.....

28. U hopola hore ke melemo efe eo lingaka tsa sekhoaa li e fumanang tsebelisanong 'moho?

.....

29. Ke bakuli bafe bao u ba fetisetsang lingakeng tsa sekhoaa ho fumana pheko?

	YES	NO	
Letsollo	1	2	24
Lefu la tsoekere	1	2	25
Lefu la phallo ea mali	1	2	26
A mang (hlalosa)	1	2	27

30. Ke bakuli ba mafu a feng ba romelloang ho uena ke lingaka tsa sekhoaa ho fumantsoa phekolo?

	YES	NO	
Ho akheha	1	2	28
Koatsi ea bosolla tlhapi	1	2	29
Lefuba	1	2	30
Lefu la phallo ea mali	1	2	31
A mang (hlalosa	1	2	32

31. Maikutlong a hau u ka etsang ho ntsetsa tsebetso pele ea bophelo bo botle secha beng?

.....

.....

.....

ANNEXURE C
REQUEST FOR SUPPORT TO
THE DIRECTOR PRIMARY
HEALTH CARE

Queen Elizabeth II Hospital
P.O. Box MS 122
Maseru 100.
3/6/98.

The Director
Primary Health Care
Maseru 100.

Sir/Madam,

I am a part-time student at UNISA. As a requirement for a doctoral degree, I am expected to submit a thesis for my study.

My research topic is collaboration between traditional healers and nurse practitioners in primary health care.

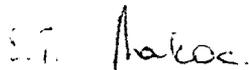
The purpose of my study is to explore and describe the existing relationship between traditional healers and nurse practitioners in primary health care.

The target population is the nurse practitioners working in the clinics around Maseru Health Service Area (HSA) and traditional healers within the same HSA.

I therefore, wish to solicit your support in carrying out this study.

Thank you in anticipation

Yours faithfully,



E.T. Makoa (Student No.3100-566-7)

ANNEXURE D

REQUEST FOR SUPPORT TO THE

CHAIRMAN LESOTHO UNIVERSAL

MEDICINEMEN AND HERBALIST

COUNCIL

Queen Elizabeth II Hospital
P.O. Box Ms122
Maseru 100.
3/6/98

The Chairman
Lesotho Universal Medicine men
& Herbalist Council
Lesotho.

Dear Sir/Madam,

I am a part-time student with UNISA. I wish to conduct a study for a doctoral degree on collaboration between traditional healers and nurse practitioners in Maseru Health Service Area.

I therefore request your office to support me by identifying some of the traditional healers known to you who can agree to participate in the study.

Thank you in anticipation.

Yours faithfully


E.T. Makoa
(Student No.3100-566-7)

ANNEXURE E
REQUEST TO CHAIRMAN
RESEARCH COMMITTEE

Queen Elizabeth II Hospital
P.O. Box 122
Maseru 100.
5/3/98.

The Chairman
Research Committee
Ministry of Health & Social Welfare
Maseru 100.

Dear Sir/Madam,

I am a part-time student with UNISA. As part of the requirement for a doctoral degree, I am expected to submit a thesis for my study.

My research topic is collaboration between traditional healers and nurse practitioners in primary health care.

I therefore wish to submit my application for support and permission to carry out the study. The purpose of the study is to explore and describe the existing relationship between traditional healers and nurse practitioners in primary health care.

The target population is the nurses working in the clinics around Maseru Health Service Area (HSA) and the traditional healers within the same HSA.

Thank you in anticipation.

Yours faithfully

E.T. Mako (Student No.3100-566-7)

ANNEXURE F

REQUEST TO NURSE PRACTITIONERS

TO PARTICIPATE IN THE STUDY AND

IDENTIFY TRADITIONAL HEALERS

Queen Elizabeth II Hospital
P.O. Box MS122
Maseru 100.
10/6/98.

Dear Colleague,

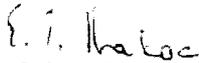
I am a part time student at UNISA. As part of my requirement, I have to submit a thesis for a doctoral study.

My research topic is collaboration between traditional healers and nurse practitioners in primary health care. The target population is nurse practitioners working in the clinics around Maseru Health Service Area and traditional healers from the same health service area.

I therefore request you to support the study by completing the attached questionnaire and by identifying traditional healers who would be willing to participate in the study. Traditional healers will be interviewed on the dates to be agreed on.

Your assistance will be highly appreciated.

Yours faithfully,



E.T. Makoa (Student No.3100-566-7)

ANNEXURE G
QUESTIONNAIRE FOR NURSE
PRACTITIONERS

Questionnaire for Nurse Practitioners

--	--

SECTION 1:

BIOGRAPHICAL DATA

1 - 2

1. Sex:

M

1

3

F

2

2. Age:

0 - 19 years

1

4

20-39 years

2

40-59 years

3

60 and above

4

3. Religion:

Catholic

1

5

Anglican

2

L.E.C.

3

Apostolic

4

Other (specify)

5

4. Marital status

Married

1

6

Widowed

2

Single

3

Divorced

4

5. What is your professional qualification?

Registered Nurse

1

Enrolled Nurse

2

Nursing Assistant

3

Other

4

7

6. In which residential area do you live?

Urban

1

Periurban

2

Rural

3

8

7. For how long have you been in this practice?

0 - 5 years

1

6 - 10 years

2

11 - 15 years

3

16 - 20 years

4

21 and other

5

9

SECTION 2 : PRIMARY HEALTH CARE

8. What is the average number of clients who attend the clinic daily?

1 - 20

1

21 - 40

2

41 - 60

3

61 - 80

4

80 and above

5

10

9. How often does the doctor visit your clinic?

Daily

1

Twice a week

2

Once a week

3

Once a month

4

Other

5

11

10. How many nurses work in this clinic according to their levels?

Registered Nurses

1

2

3

12

11. Enrolled Nurses

1

2

3

13

12. Nursing Assistants

1

2

3

14

13. When you treat a patient, do you see him as an individual or as a member of the family?

As an individual

1

As a member of the family

2

15

14. Explain why?

.....

.....

.....

14. When you treat a patient, how do you involve the significant others in the care?

	YES	NO	
Does not involve them	1	2	16
Explain the cause of disease	1	2	17
Explain how medicine should be taken	1	2	18
Explain when to come for follow-up	1	2	19
Other	1	2	20

15. Please explain any other.

.....

.....

.....

SECTION 3: INVOLVEMENT OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE

16. How do you involve traditional healers as members of the community in primary health care?

Refer patient to traditional healers	1	21
Hold gathering to discuss health issues	2	
Others	3	

17. Explain "others"

.....

.....

.....

18. Indicate how you think traditional healers could be utilized effectively in primary health care.

	YES	NO	
Prevention of common illness	1	2	22
Education of community on health issues	1	2	23
Support on home based care on HIV/AIDS	1	2	24
Other	1	2	25

19. Explain "others"

.....

20. In your opinion, why do you think people consult?

Health Care Practitioners

.....

Traditional Healers

.....

21. In which conditions do you think traditional healers are effective in the treatment of patients.

	YES	NO	
Aids	1	2	26
Tuberculosis	1	2	27
Gastro-Enteritis	1	2	28
Other	1	2	29

22. Explain "other"

.....
.....
.....

SECTION 4: SUPPORT SYSTEM AVAILABLE TO TRADITIONAL HEALERS

23. What type of support do you give to traditional healers in your area?

	YES	NO	
Does not offer any support	1	2	30
Gives them training	1	2	31
Holds meetings	1	2	32
Other	1	2	33

24. Explain "other"

.....
.....
.....

25. Do you refer clients who do not respond to treatment to traditional healers?

YES	1	34
NO	2	

26. If yes, explain why

.....
.....
.....

27. If no, explain why?

.....
.....
.....

28. Which patients have you referred to traditional healers?

	YES	NO	
Tuberculosis	1	2	35
Aids	1	2	36
Hypertension	1	2	37
Diabetes	1	2	38
Diarrhoea	1	2	39
Others	1	2	40

29. List others.

.....
.....
.....

30. Which patients have you treated that have been referred to you by Traditional Healers?

	YES	NO	
None	1	2	41
Tuberculosis	1	2	42
Aids	1	2	43
Diabetes	1	2	44
Others	1	2	45

31. List others.

.....

.....

.....

32. Does the traditional healer accompany his/her clients to the clinic?

Never

1

Sometimes

2

Always

3

46

33. Do you have any programme for traditional healers in primary health care?

Yes

1

No

2

47

34. Briefly explain the programme.

.....

.....

.....

36. How often do you offer these programmes

Weekly

1

Monthly

2

Other

3

48

37. How many traditional healers are involved in these programmes?

1 - 5

1

6 -10

2

10 and above

3

49

38. Where are the programmes held?

At their homes

1

In the village

2

At the clinic

3

50

39. Who is involved in teaching?

Nurses

1

Village health workers

2

Others

3

51

40. Explain "others"

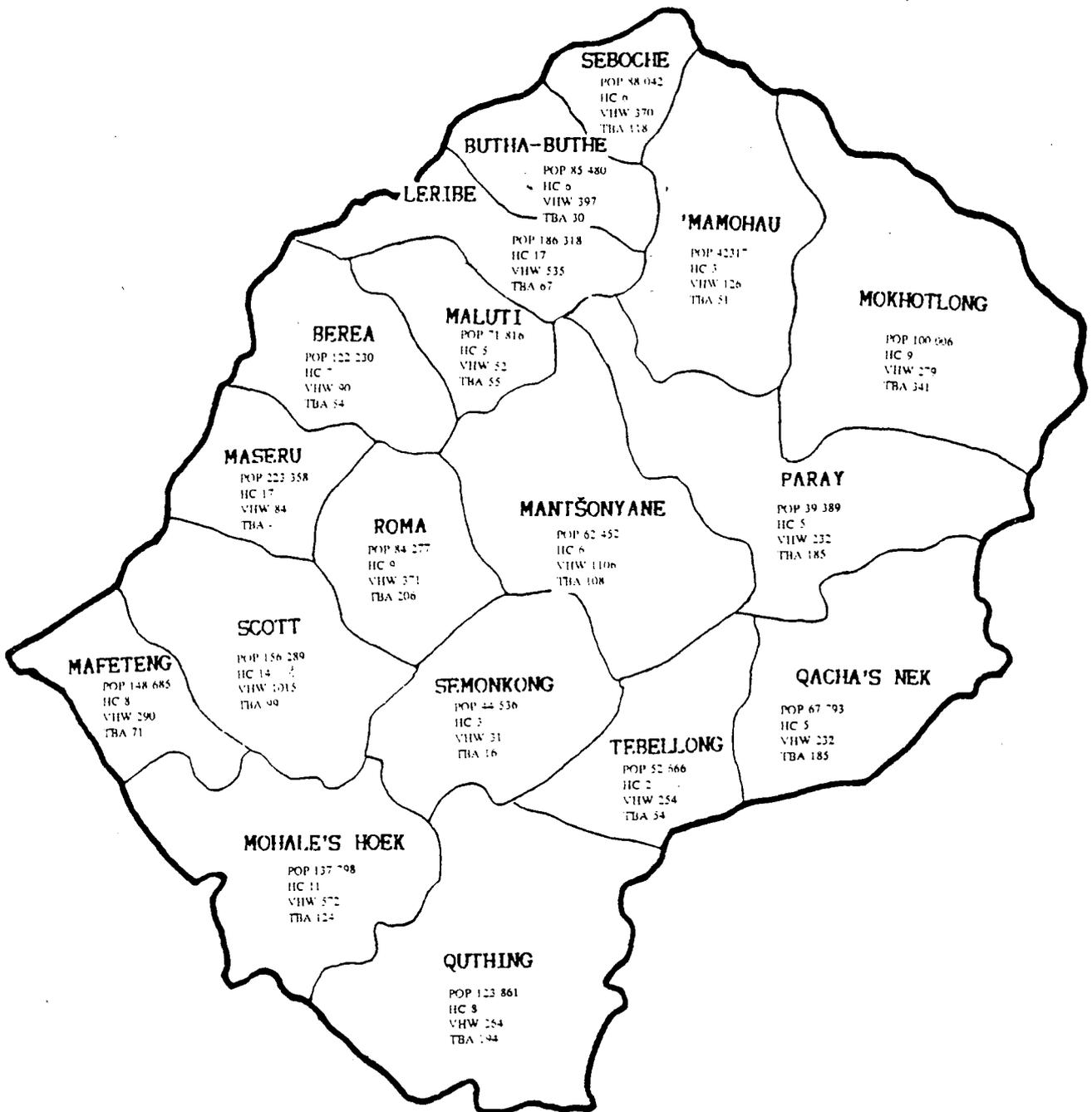
.....
.....

41. What type of cooperation between traditional healers and nurse practitioners do you think can benefit the community?

.....
.....

ANNEXURE H
THE HEALTH SERVICE AREA MAP
OF LESOTHO

Health Service Area Map of Lesotho



Source: Ministry of Health 1992

Pop = Population of Health Service Area
 HC = Health Centres in HSA
 VHW = Village Health Workers in HSA
 TBA = Traditional Birth Attendants in HSA

ANNEXURE I
PERMISSION FROM THE MINISTRY
OF HEALTH AND SOCIAL WELFARE
TO CONDUCT THE STUDY



LESOTHO

Ministry of Health
& Social Welfare
P.O. Box 514
Maseru 100

REF NO. : H/PROJ/40

18 June, 1998

Mrs. E.T. Makoa
P.O. Box 122
MASERU. 100

Dear Mrs. Makoa

**RE: PERMISSION TO CONDUCT A STUDY ON COLLABORATION
BETWEEN TRADITIONAL HEALERS AND NURSE PRACTITIONERS IN
MASERU HEALTH SERVICE AREA - LESOTHO**

Reference is made to your letter of 5 March 1998, with which you requested to conduct the above mentioned study.

Your proposal was submitted to the Advisory Research Committee. The Committee found your study to be crucial in understanding how best the health professionals and Traditional Healers can work together in the provision of health care.

With this letter, therefore the Ministry of Health approves your request to carry out a study on collaboration between traditional healer and nurse practitioners.

Yours faithfully,

**DIRECTOR GENERAL
FOR HEALTH SERVICES**