TRADITIONAL HEALING AS A HEALTH CARE DELIVERY SYSTEM IN A TRANSCULTURAL SOCIETY

by

Julia Elisa Bereda

Submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. O.N. MAKHUBELA-NKONDO

2002

DECLARATION

I ***Julia Elisa Bereda*** declare that "Traditional Healing as a Health Care Delivery System in a Transcultural Society" is my own work, and that all the sources I have used and quoted have been indicated and acknowledged by means of complete references.

Bereda

Miss Julia Elisa Bereda

14.08.2002

Date

DEDICATION

I dedicate this work to my whole family: my parents, spouse, children, siblings and all my relatives for the contribution they have made in my entire social, intellectual and human development.

ABSTRACT

This study analyzed the role of traditional healing as a health care delivery system in the context of a transcultural society. The perspectives, experiences and personal accounts of 90 respondents were assessed with respect to the categories used by the World Health Organization in its goal of primary health care. Focusing in the research setting that was based in the Limpopo Province, in South Africa the researcher sought to determine whether health practitioners appreciated and understood traditional healing system; if health institutions could integrate traditional healing systems; and how collaboration of the two health systems can be realized. Furthermore, drawing on a blend of qualitative and quantitative research design, the research project was intended to establish the extent to which traditional medicine equipped health practitioners with knowledge of traditional healing techniques and whether practitioners would reconcile traditional and conventional medicine.

Drawing on a modified version of the structure of Leininger's Sunrise model, which states that cultural, physical and social structure dimensions are influenced by multiple factors. The research findings offer insights into the historical, social, economic, cultural, among other developments, that lead to integrationist approach in health care systems. Concluding remarks that health practitioners should pursue a policy of neutrality follow a discussion of the findings, emphasizing, the need to allow health consumers to seek traditional health care system, if they so desire. Recommendations include suggestions for further research to determine effective partnerships between traditional and conventional health care systems.

ACKNOWLEDGEMENTS

I extend my sincere gratitude and honour to God my creator, God the Son and God the Holy Spirit for the wisdom and knowledge I had been given.

Furthermore I wish to express my special thanks and appreciation to the following persons:

- Professor O. Makhubela-Nkondo my supervisor, who genuinely advised, guided, supported and encouraged me throughout my entire study period.
- Professor R. Troskie, for the support she gave me until her retirement.
- Dr. L. De Viliers, my joint supervisor, who took over and gave me much encouragement, guidance and support.
- All my informants for their valuable contributions.
- The Northern Province Department of Health for allowing me to conduct the study.
- Mr. A Mulaudzi & Mr & Mrs Mudau for organizing and printing the whole project.
- My children, Ronny, Bontu, Awelani and Ramudzuli Midana for their undivided support.
- My brother in law, Mr. Thomas Maelekanyo and Rudzani Mulaudzi for their interest and support.
- My father, Mr. Petrus Bereda, my brothers, Tshimangadzo and Muravha, my sisters, Lufu, Mpho, Gumi, Masala and Konanani for their motivation.
- My friends in Christ Mr. & Mrs. Ratshibvumo for their unqualified sacrifice, love and support they offered throughout my study, may God bless them.
- Lastly, my loving husband, Dr Muofhe Mulaudzi who encouraged me when I thought it was not necessary to continue, may God bless him.

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	=	Acquired Immuno Deficiency Syndrome
ANC	=	African National Congress
GNU	=	Government of National Unity
HIV	=	Human Immuno Virus
PHC	=	Primary Health Care
RDP	=	Reconstruction and Development Programme
RHT	=	Refusal of Hospital Treatment
WHO	=	World Health Organization

LIST OF APPENDICES

TABLE OF CONTENTS

CHAPTER ONE

OVERVIEW AND PROJECT DESIGN

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

In South Africa and some African states, patients have a wide range of options to deal with illness. That is, starting from self-help/treatment to traditional health or "modern" health care, which will be described as regular health care. The sick individual has an option to use the different methods concurrently or alternatively. The evolution of traditional societies seems evident. This transition is uneven in some structures/institutions of many societies. One institution faced with this challenge is the health care system. Previously African traditional health practices were distorted and despised. The regular health care was regarded as superior to indigenous health care system. Traditional healers were classified as "witch doctors" who exploited the ignorance and superstitiousness of the unenlightened natives (DeJong 1991:2; Van Rensburg, Fourie & Pretorius 1992:320).

Currently people seem to hold different perceptions regarding health care services. Those who opt for traditional healing may occasionally be considered superstitious, irrespective of the reason and/or the outcome of the consultative process. There is a need to understand and recognize traditional healing as well as incorporating it into the health care delivery system.

The Government of National Unity (GNU), (RDP document of 1994) stresses the reorganization of the health care services, in order to give South Africans access to an effective, affordable, acceptable and accessible health service resulting in a physically, psychologically and socially healthy population (ANC 1994 (b):43).
The concept, "Health for all" (WHO, 1978:1) implies the involvement of all health practices. Among these, are traditional healers and village health workers. The

participation and involvement of other practitioners and communities are in line with the principles of Primary Health Care (PHC). However, these continue to be inadequately understood and developed. Acco:ding to Wolffers (1990) in Vontress 1991, there are numerous views and opinions within the health care systems that have been considered, but none of them has addressed the need to operationalize the involvement of traditional healing into the health care delivery system for a multicultural society (Vontress 1991:12).

1.2 STATEMENT OF THE PROBLEM

How are the modernised or formal and the traditional health care systems incorporated into the health care delivery in Region 4 of the Northern Province? In its National Health Care Plan; the Government of National Unity (GNU), emphasized the need to utilize all available health resources, as well as the re-organization of health services, which does not exclude traditional healing methodology in particular. The main aim is to allow all South Africans access to effective, affordable, acceptable and accessible health service, resulting in a physically, psychologically and socially healthy population (ANC 1994 (a):43).

South Africa is a multicultural society of whose health care delivery is mostly westernized, thus ignoring the fact that health care consumers/clients are denied the chance to use both modern and traditional health care systems. If modern health care system fails to incorporate the traditional system we would fail to satisfy the needs of our clients. The problem deals with the fact that the incorporation of the modernised health care system has to be identified in the delivery of health care in Region 4 of the Northern Province (ANC 1994: 44).

Bellakhdar (1989) puts emphasis on the need to incorporate and utilize optimally all of the country's resources. These include human as well as material resources. Traditional and modern methods are essential in the development and enhancement of the public health system. At a recent workshop on HIV/AIDS, practitioners from

diverse backgrounds and orientation participated. Five of these were traditional healers who attended a course voluntarily for two weeks on HIV/ AIDS, urinary infections, gastro-enteritis, nutrition etc. One of the traditional healers commented "there is a lot we traditional healers can learn from nurses and doctors and they can also learn from us" she continued to say "there are some illnesses that are cured better by traditional healers while others can only be treated by doctors." These two statements warrant an appreciation of traditional medical concepts. If not, intersectoral collaboration and cost effective health care service would be difficult to implement (Khupiso 1996: 2).

The media has also given traditional healing pronounced attention. The recent coverage on traditional healing was published in a national newspaper. It read as follows:

"...When ancestors call no one can stop it."

This was a description of a Caucasian medical technician who once worked at Groote Schuur and Johannesburg hospital. This individual had recently swopped her stethoscope for the "bones" that are normally used by traditional healers (Eland 1996:35).

The researcher's 14 years of experience as a nurse in two hospitals in South Africa, in the Northern Province is significant here. She has witnessed poor relationships among practitioners (doctors and nurses) and patients as well as their relatives. The health practitioners sometimes get frustrated by the insistence of some clients to utilize the services of the traditional healers. The regular health practitioner regarded this as unhealthy. Most of these practitioners could not appreciate how cultural differences on the overall health status of the client. It was common practice to for some doctors and nurses to refuse to grant patients the permission to go and consult traditional healers of their choice while hospitalized.

In many instances, patients were forced to sign a "Refusal of Hospital Treatment" (RHT) form, and would experience ambivalent feeling towards both doctors and nurses in charge. For fear of being forced to sign a Refusal of Hospital Treatment, most patients resorted to several subtle avenues, to utilize these services concurrently. For instance, some patients politely asked for a temporary discharge over the weekend, usually citing socially acceptable reasons. On their return to hospital, nurses would observe some physical or manifestation of traditional healer's intervention such as cuts or apparel used for treatment. This would be a clear indication that patients had visited a traditional healer although they would not reveal this to the practitioners in the clinics or hospitals. These and other practices were in direct contrast to the principles of the Patients Rights Charter which states that health consumers are entitled to exercise the right to choose the type of health care service they prefer (Department of Health 1999:10)

Clients were compelled to be dishonest to the health practitioners because they avoided negative perceptions of their practices. Others delayed hospital visits. In numerous instances patients would only come to the hospital at an advanced stage of their illness. These and other complications, which could be avoided, forced the different sectors to negotiate the need to allow the client to practice their beliefs openly for the sake of anticipatory guidance and action. In order to attain Health for All by the year 2000 and beyond, traditional medicine/healing should become an integral part of the health care delivery system in South Africa which would help the Ministry of Health to attain its objectives (ANC 1994 (a):55).

1.3 SIGNIFICANCE OF THE PROBLEM

It is hoped that this study would strengthen the goal of "Health for All by the year 2000" and beyond as proposed by the World Health Organization in its goal of primary health care delivery in South Africa (ANC 1994:1). The knowledge generated through this research would add to the existing knowledge of nursing care with regard to cultural diversity in nursing care delivery as well as the

incorporation of traditional health care in Region 4 of the Northern Province. One of the principles of the health care system is the utilization of the available resources such as traditional health care (ANC 1994 (a):1).

1.4 PURPOSE OF THE STUDY

The study was intended to establish the extent to which traditional medicine equipped health providers with the knowledge of traditional healing methods and its related diagnostic techniques. The intention was to further distinguish among different traditional methods in the area, and the way in which these had an influence on health to reconcile differences between modern and traditional healing. Specifically the study aimed,

- to establish to what extent traditional healers are being used;
- to evaluate health and illness behaviour of every client under the care of traditional healers;
- to be able to distinguish among different traditional methods in the area, and their influence on human health;
- to incorporate traditional healing system in the formal health care system;
- to establish recommendations for collaboration of the two systems;
- to reconcile differences between regular and traditional healing methods.

Some of the relevant trends for this study included the following perspectives:

- Traditional healing has been treated as a subculture in the health sciences discipline.
- The indigenous knowledge systems have subsequently highlighted its significance.

- Health as a category, includes a variety of practices, attitudes, and beliefs held by different health consumers, traditional healing is regarded by those who utilize it as a viable intervention strategy.

1.5 RESEARCH QUESTIONS

This study was intended to achieve the objectives stated in the following questions.

(a) What is the level of awareness about the existence of traditional health care system?

(b) What collaboration exists between traditional healers and health care professionals?

(c) What are the illnesses/diseases/conditions that are treated through traditional health care system?

(d) How are traditional healers perceived by health professionals and health care consumers?

(e) What are the views of traditional healers and health professionals regarding legalization of traditional health care system?

The questionnaire items have also emerged from these main questions. The following conceptual framework was also important in the development of the research questions.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.0 Sangoma

The sangoma, may be described as a traditional healer who may be a male or female practitioner who normally undergoes training to be able to diagnose, predict and/or heal clients by using herbs and/or roots, including other indigenous substances that have medicinal properties.

1.6.1 Traditional Healer

A traditional healer is defined as "someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and causation of the disease and disability in the community (Van Rensburg et al., 1992:328)

1.6.1.1 Diviner, Nanga (Venda) / Ngaka (Sesotho) / Inyanga (Zulu)

Diviners concentrate on the diagnosis of mysteries. They analyze the cause of special events and interpret the messages of the ancestral spirits. They use divination objects or explain the unknown by the special powers of prophecy. Their function is that of divination, but they often also provide the medicaments for specific cases diagnosed by them (Van Rensburg et al., 1992:328).

1.6.1.2 Herbalists

According to Harmmond-Tooke (1974) in Van Rensburg et al., (1992), herbalists are "ordinary people who have acquired an extensive knowledge of marginal technique and who do not, typically, possess occult powers" (Van Rensburg et al., 1992:329).

Herbalists diagnose and prescribe medication for ordinary ailments and alleviate misfortune and disaster, to provide protection against sorcery and misfortunes and to promote happiness.

1.6.1.3 Faith Healers/Prophet

Faith healers/prophets actually indicate syncretism, a reinterpretation of orthodox Christianity in such a way as to be reconcilable with traditional culture. Strictly speaking prophets are therefore no traditional healers, yet they have the following in common with the traditional healer (Van Rensburg et al., 1992:330):

- A shared theory of disease and health.
- A similar means of divination, although God or the Holy Spirit, rather than ancestral spirit aids him.
- The treatment of various diseases, including the so-called culture related syndrome.

1.6.2 Traditional Healing

This is the technique used by traditional healers, singly or interactively to eliminate, ameliorate or prevent physical, psychological and spiritual problems of patients with the use of special divine powers (Vontress 1991:242).

1.6.3 Multi-Cultural Society

This is a society whose participants differ in cultural background, values and life styles (Speight et al., 1991:29). This involves human diversities that exist in a given society with regard to their interconnectedness as well as their effective interactions.

1.6.4 Health

"A state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity" (World Health Organization, 1992:23). Health, according to Neuman (1990:129), is energy as a result of system balance. The client (community, groups, individual) as a system, constantly monitors itself by making adjustments as needed to attain and maintain stability for an optimal state of health.

1.6.5 Health Care

The output of health services to the community (Stanhope & Lancaster 1992:23)

1.6.6 Health Care System

The organization and distribution of all the resources a society allocates for health service (Stanhope & Lancaster 1992:23). According to Clark (1992:35), health care system is all of the societal services and activities designed to protect or restore the health of individuals, families, groups or communities.

1.6.7 Modern/Western Health

Modern/Western health is refers to as official, cosmopolitan, and/or allopathic medicine, which comprises of a system of knowledge, beliefs and practices which can be verified only empirical, and entails a continued search for methods to make the practice more efficacious. This knowledge is dominated by the scientific standards of proof and is generated and evaluated by the community of practitioners and researchers (Van Rensburg et al., 1992:310-311).

1.6.8 Health Professionals

In this research study, the researcher shall refer to doctors, nurses, paramedics, etc, who are registered under any recognized professional controlling bodies in South Africa as medical practitioners or health professionals.

1.6.9 Collaboration

Collaboration is seen as the process of working together in a climate were mutual assistance and help is provided by two parties to attain a common goal. In this context the goal is a healthy community. It is also a process whereby conflicting parties are brought into harmony with each another. It is not integration, as each group would still be functioning in its own sphere, but with the support of the other (Troskie 1995: 2).

1.7 RESEARCH DESIGN

Methodologists such as Polit and Hungler (1993) have described research design as the overall plan for obtaining the answer to the research questions and for testing the research hypothesis. The design spells out the strategies that the researcher adopts to develop information that is accurate, objective and interpretable. These strategies are addressed in detail in Chapter Three.

1.7.1 Setting or Background

This research would be conducted in South Africa in Region 4 of the Northern Province as indicated in the maps. The two maps give an overview of hospitals, health centres, and clinics that are found in Region 4. These areas are heterogeneous. Consisting of Vhavendas, Vhatsonga, Ama-zulus and Basotho. Inclusivity resulted from intermarriages, the country's

geographical coherence in terms of demarcations of regions as well as migrant labour.

1.7.2 Population and Sampling

Brink and Wood (1998) describe population as the entire aggregation of cases that meet a designated set of criteria. The population included a sample of traditional healers, a sample of health professionals and that of health care consumers in Region 4 of the Northern Province.

While Polit and Hungler (1993) and Bodibe (1988:13) refer to sampling as the process of selecting a portion of the population that represent the entire population. In this study the researcher used non-probability sampling focusing on convenience sampling. This method is used where the researcher failed to identify the "Parent-population." "*Parent-population*" means the universe from which the sample is drawn for a particular study. For example, it may be difficult to know the total number of traditional healers, health professionals as well as health consumers in the area under investigation/study.

Participants' ages ranged between 24 and 70 years. Men and women were included. Their disciplines involve Diviners/Healers, Herbalists, Faith Healers/Prophets, Health professionals and Health Consumers. This gives a population of 45 participants.

1.7.3 Method of Data Collection

Data collection is the gathering of information needed to address a research problem (Polit & Hungler 1993). In this study questionnaires were given to those who could read and write for them to complete. For the illiterate the researcher conducted structured interview using the same items listed in the

questionnaire. Personal interviews allow first hand information of people at times when they are engaged in their real functional environment.

Data were gathered by means of triangulation of data collection techniques. Triangulation is the use of multiple methods or perspectives to collect and interpret data about some phenomena in order to converge representation of reality (Polit & Hungler 1993:448). Three different types of semi-structured questionnaires were used for the three different categories of informants. The researcher used data triangulation to be able to interview multiple key informants about the same topic (Polit & Hungler 1993:254).

1.7.4 Validity and Reliability

A pilot study shall be conducted for the feasibility of this study. A pilot study is a small-scale version, or trial run, of the major study. The function of the pilot study is to obtain information for improving the project or assessing its feasibility. With this trial run revisions may be needed in one or more aspects of the project, for example, the type of words used in the questionnaire may need restructuring. Pretesting of the questionnaire is equally important. Written permission will be sought from the Department of Health in the Province (Polit & Hungler 1993).

1.7.5 Ethical Concerns

Health care professionals are bound to have ethical standards when they work with patients of diverse background. The researcher was guided by the understanding that participants' basic rights in their participation in this research would be protected. Ethical concerns defined bellow shall be fully explained in chapter three of the study.

1.7.5.1 Right to full disclosure

It is the duty of the researcher to acknowledge the principle of human dignity and respect, which involves people's rights to make, informed voluntary decision about their participation in the study. Full disclosure of the nature of the study should be made to all participants. Clarity should be made regarding the fact that no persons should be intimidated or given any prejudicial treatment in case he or she needs to withdraw before or during the research process.

1.7.5.2 Informed consent

Informed consent means that people have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice, enabling them to give voluntarily consent to participate in the research or decline if they so wish (Polit & Hungler 1993:359).

The researcher will provide the participants with a letter/form to complete before they participate in any activity of the research study. This exercise allows an individual to make an informed decision of whether to participate or not. Human beings are autonomous agents who are capable of controlling activities into which they need to involve themselves.

1.7.5.3 Right to fair treatment

All participants regardless of their status or social position will be treated equally and with respect throughout the study regarding the following:

- Any agreement made like giving of money or awards will be adhered to,

- Access to professional assistance by participants in case of any psychological, emotional or physical damage during the study process will be negotiated,
- No prejudicial treatment will be given to the participants in case they decide to withdraw their participation, and
- Free access to the researcher by the participants for clarity will always be acceptable.

1.7.5.4 Right to privacy

Due to the possibility of intrusion of participants' personal lives in any research involving human beings as subjects, the researcher should ensure maintenance of privacy throughout the study processes to maintain human dignity. Confidentiality should also be adhered too through anonymity to avoid linking individuals with certain sets of information (Polit & Hungler 1993:363). The letter of agreement was given to every participant to complete before they participated in the study. The researcher made a verbal request to those who could read nor write to get consent.

1.7.6 Data Analysis

A blend of quantitative and qualitative data analysis will be done because questionnaires have been semi-structured. The questionnaires included both open and close-ended items. The close-ended items allowed participants to write comments. Data analysis will be of a descriptive nature, although little evidence of qualitative data has been exposed. The researcher will concentrates on content analysis for the latter, and will make sure that all questionnaires are identified according to numerical order in order to evaluate the turn over, then coding could be done. *Coding* is the process of "translating" verbal data into categories or numerical form, if necessary. This data were then transferred to a computer for analysis if necessary.

1.7 SUMMARY

Traditional healing cannot be undermined because it exists to within communities. It is a service rooted at a consumer's closest proximity. This makes it necessary for other health workers, e.g., nurses to give room for traditional health care system incorporation, to be able to reach health for all South Africans by the year 2000 and beyond (Mbiti 1991:14).

Therefore one has to agree that traditional healing is also an essential service already existing within people's reach, with norms and values well understood by its customers.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

According to Polit and Hungler (1995:433) conceptual framework is the

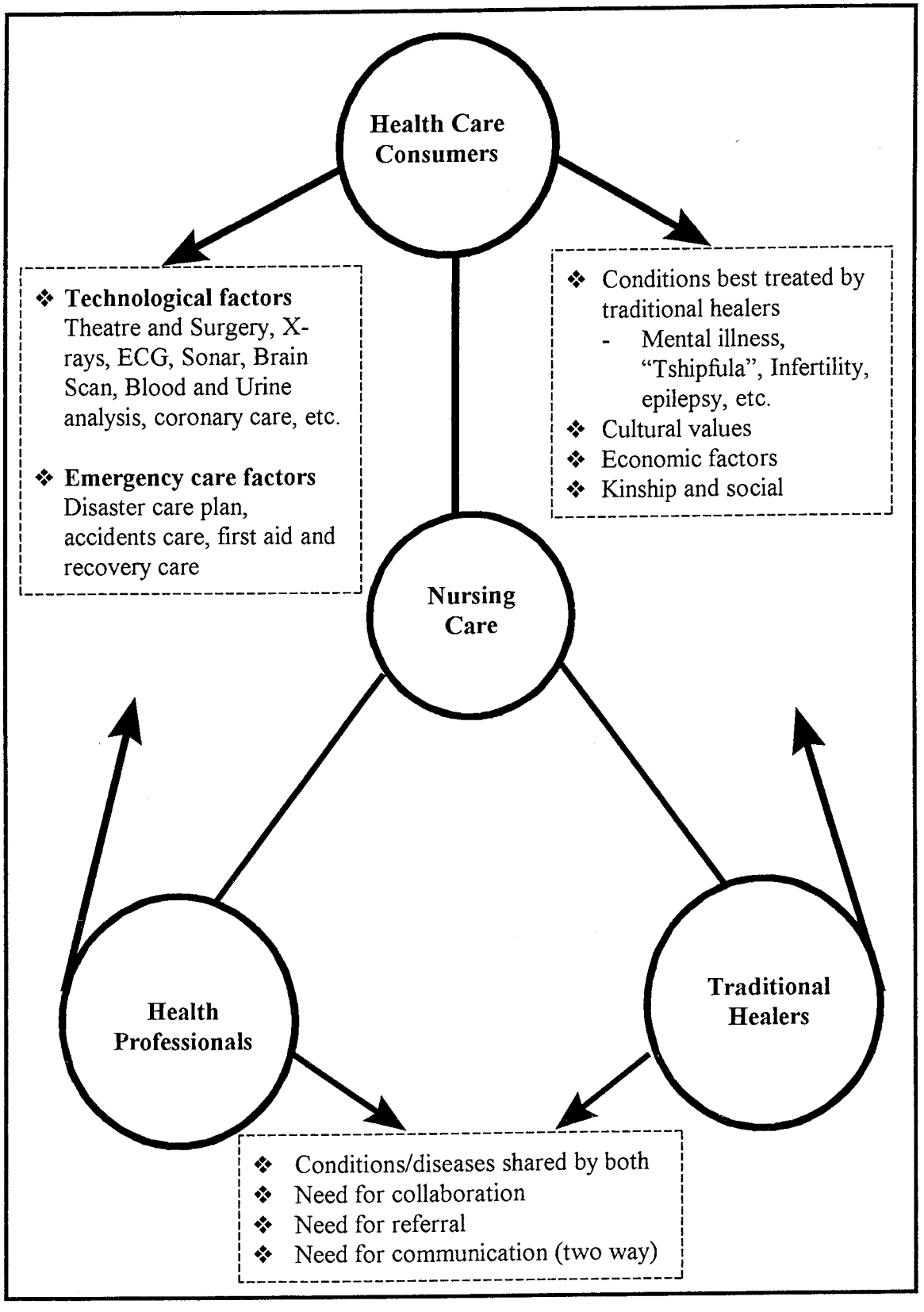
> interrelated concepts of abstractions that are assembled together in some rational scheme by virtue of their relevance to a common theme.

While Miles & Huberman (1994) explain the rationale for conceptual frameworks as labels necessary to organize intellectual information with various discrete "events and behaviours". These factors are borne out of theory and experience as well as the objectives of the study. They describe conceptual framework as in these terms:

> A conceptual framework explains, either graphically or in narrative form, the main things to be studied - the key factors, constructs or variables - and the presumed relationships among them. Framework can be rudimentary or elaborate, theory-driven or commonsensical, descriptive or causal.

Figure 2.1

Modified structure of Leininger's model



Cultural factors seem to be very important in the study of traditional healers in a transcultural society. Determining the traditional healers' role and their actual practices is critical for the successful incorporation process. Several factors have been used to describe traditional healing in a transcultural setting. The theoretical framework that seems to provide a somewhat relevant model is the one provided by Leininger (1991) on Sunrise model. The Sunrise model is the mechanism by which health care consumers, health institution and/ health practitioners, as well as health professionals seem to collaborate effectively provided all the factors involved are reconciled.

Culture is a concept that has been applied to diverse situations, particularly in a situation where traditional healers and conventional practitioners have to collaborate. It is a multilevel and multidimensional concept that addresses social behavioural as well as political and interpersonal related matters (Helvie 1998).

The presentation of theoretical framework in Figure 3.2 above, is an adjustment of the Sunrise model (Leininger 1991b: 49). According to Leininger (1991) cultural care and social structure dimensions are influenced by multiple factors. The others factors included the following:

2.1.1 Educational Factors

As stated by Jackson and Meadows (1991) philosophical assumptions influence the education background of the specific group and affect belief systems or one's cultural worldview.

2.1.2 Economic Factors

Some traditional healers may adjust their practices based on their financial or economic standing. For instance, there is a debate on how the health insurance schemes, would cover services provided by traditional healers.

This incentive could promote the practice of traditional healing system. With modern health care system most of the life serving care e.g., coronary/cardiac care, brain scan, theatre and surgery are very expensive. This brings out the idea of medical scheme usage as well as the awareness by traditional healers that the above services can only be offered by health practitioners hence inter-collaboration. Some traditional healers do treat their patients on credit, for them to pay later or use any other substitute for the payment like, a goat or a cow.

2.1.3 Emergency Care Factors

At the present moment modern health care system provides for emergency services for patients at risks e.g., accident care plan, disaster care plan, first aid and recovery care services. These services call for both health care consumers and traditional healers to acknowledge and utilize them.

2.1.4 Cultural Values

Though transcultural nursing is a point of departure in nursing it still has some shortcomings. For example, traditional healers are the once who fully acknowledge the idea of cultural beliefs, values and norms of each individual client.

2.1.5 Kinship and Social Factors

Modern health care has a tendency to temporarily break bonds between patients and their next of kin except in the case of a breast-feeding mother. The traditional healer accepts the family to come and stay with their patients throughout and give help and care, this includes the family in the teamwork.

2.1.6 Need For Collaboration

Looking at Figure 3.2 of the theoretical framework the two services (traditional and modern) need to merge in order to complement each other for the benefit of the health care consumers.

2.1.7 Need for Communication

There should be a two-way communication style for both traditional healers and health professionals. It will then be necessary for them to consider each other services and promote referrals to and from.

2.1.8 The Appropriateness of Leininger's Model

The Sunrise model by Leininger (1991) is quite suitable for the study because it deals with some of the critical areas that may act as confounding variables.

2.1.9 Awareness

The level of knowledge or cognizance regarding traditional healing as health care delivery system is essential for determining the extent to which people utilize these services.

2.1.10 Collaboration

The alliance or partnership among the community members and those practicing traditional healing needs to be explored. The stronger the association, the more frequent would be the utilization of these services.

2.1.11 Acceptance

One of the principles of primary health care include the notion of acceptance. Affirmation, deference or compliance is essential for the traditional healing process to be effective and acknowledged as significance.

2.1.12 Legalization

The state has the obligation to determine the lawfulness or validity of such healing system. Once this has been deemed permissible then an authoritative structure will through a judicial system provide license for practicing.

2.1.13 Training

Preparation of those individuals who have to provide traditional healing need to be regulated. The guidance or instruction determines to a great extent its transcultural nature.

2.1.14 Referral

The consumers of this system of traditional healing have to recourge the transfer and share the relevance of this trade to ensure that its applied broadly.

2.1.15 Conclusion

The second chapter provides a conceptual framework which assembled relevant themes to organize intellectual information to various events and behaviours in a graphical and narrative form. The variables that have been discussed, among others, include cultural values, kinship and social factors and the legal factors that are borne out of theory and experience.

CHAPTER THREE

LITERATURE REVIEW

3.1 INTRODUCTION

Man can never be an island, but will continually form part of the system, the larger environment. Man is also susceptible to illness originating from different elements/stressors surrounding him or her in any given type of an environment. Klein (1979:1) reflects a perspective that stress is endemic to life and that to realize a full life one must experience stress. Klein (1979:2), claims that perfect health is incompatible with the process of living. Perfections of health and illness differ from one person to the other and from culture to culture. These diverse perceptions bring forth differences and similarities that depend on a multitude of complex social, cultural and environmental factors.

Mankind lives under a three-fold type of environment, that is, the natural environment, the social environment, and the imaginary environment. The physical and the animal world affect people in their search for food, which constitutes their *natural environment.* Human beings also interact with others, which constitutes their *social environment.* Thirdly, it is people's own imaginary notion concerning supernatural things, for example, spirits, ghosts, evil powers and others of related nature, and this forms their *imaginary environment* (Maddox 1977:2).

Many dimensions should be critically explored regarding health and illness behaviours, cultural beliefs, as well as the intervention strategies cross-culturally. This might bring us to a better understanding of different health systems in a multicultural society.

3.2 CONCEPTUALIZATIONS OF CULTURE AND TRADITIONAL HEALTH CARE

3.2.1 Conceptualizations of Culture

South Africa is regarded as the rainbow nation, which denotes that it is of diverse cultures. This brings us to the point of getting to know what culture is, before coming to its influence on human health. Culture represents the way people perceive and shape their world.

Health as a category of culture, includes a wide variety of practices, attitudes, and beliefs held by different people. Culture influences almost all-human activities. The way people work, the way they show respect, the way they laugh, as well as the way they interpret illnesses. These interpretations may influence health care delivery positively or negatively. It is well accepted for a white man to witness delivery of his child, but if it is done by a black man it is perceived as culturally unacceptable to many black South Africans regardless of their literacy levels (Klein 1979:1-8).

Amongst many black tribes, if one is ill and happens to be mentally confused, they would never accept the fact that an illness might have affected the brain as it could be in any other part of the body. They would simply associate behaviour with evil influences from witchcraft. Due to these cultural beliefs relatives usually remove their trust from modern treatment, and will pursue the doctor to discharge the patient, or else they would take him or her by force. This shows how culture can influence health care delivery processes (Klein 1979:1-8).

Culture is an integrated whole, made up of hidden aspects that constitutes deeper levels. Culture is, alive, dynamic, and all its elements are

interconnected, and each fulfills a specific function in the integrated scheme (Jackson & Meadows 1991: 74).

3.2.2 Components of the Deep Structures of Culture

A belief system or cultural worldview comprises various components of philosophical assumptions. These components underlying culture are ontology, cosmology, epistemology, axiology, logic and process (Jackson & Meadows 1991: 74).

Ontology refers to the nature of reality. A culture's worldview evolves from the primary premise concerning the nature of reality. Fundamental questions often asked are "What is reality?" "Who is right?," "Is reality one or many?." Ontology of culture therefore is important in understanding and interpreting behaviours. Without an ontological perspective, behaviour can be misinterpreted. Behaviours that are considered abnormal in one culture may be considered normal in another. For example, if a patient believes that he has been bewitched, it could be difficult to enter into a therapeutic relationship with the doctor, unless he/she is in touch with the patient's reality with of his/her disease causation. This shows the need to collaborate traditional medicine with modern medicine (Jackson & Meadows 1991:74).

Cosmology refers to the order and arrangement of reality. This includes a culture's concept of the supernatural, the basic nature of people and society, and the way these concepts are organized and give meaning to people's lives. Fundamental questions such as "What is the relationship between various parts of reality?" and "How does reality come to be and how does it change?" need to be addressed. When the way a culture orders reality is imposed on another culture, there is a problem. For example, a belief in evil spirits by a culture may be perceived as a negative aspect of that culture by others (Jackson & Meadows 1991:74).

Epistemology concerns itself with the nature of knowledge. It pertains to understanding the source and essence of knowledge and deals with fundamental questions such as "What is knowledge?" "Where does knowledge come from?" and "How does one acquire knowledge?" Epistemology concerns itself with the nature of knowledge.

From a Eurocentric framework, knowledge is that which is observable, written, and concrete. From an Afrocentric perspective, knowledge is acquired orally, and intuitively, through the senses. In terms of health care providers each one has to pay attention to these other ways of knowing, for example, a relative may confirm the death of a very critically ill patient that it has been confirmed by the ancestral spirits, whereas doctors are looking at it from the point of decline in progress of recovery of patient, e.g. in case of brain damage (Jackson & Meadows 1991: 74).

Axiology is the discipline that studies the nature of values by which people live. This addresses the following questions: "How do values develop? What is value and what is valuable? And "What is the highest value of a group of people?" Among Afrocentric cultures the highest value is the importance of relationships. The highest among Eurocentric cultures is the acquisition of objects. In societies wherein relationship is highly valued confrontation is always avoided. For example if the patient presents with a certain behaviour, which is either approved by his people though detrimental, it must be approached with care (Jackson & Meadows 1991:74).

Logic is the nature of reasoning and systematic inquiry into arguments, inference and thoughts. It is the study of valid arguments. A culture's primary mode of reasoning of logic influences, the way individuals respond to and interpret experiences. An example of this is seen in family relationships and gender roles. The gender role amongst Afrocentric culture tends to be

flexible, whereas in Eurocentric cultures the gender roles are rigidly defined. An African American man will more likely view staying home with children positively than will European American men (Jackson & Meadows 1991:74).

Process is a method of operation or functioning. It refers to a series of action on changes and methods to bring about actions and change. Functioning in Western culture to bring about actions and changes is primarily through technology, reproduction of materials, whereas in most non-western cultures, action and change is brought about through interpersonal relationship (Jackson & Meadows 1991: 74).

3.2.3 Conceptualizations of Traditional Health Care

It is very obvious that allopathic health care in South Africa, like in other countries of the world is not the only dominant and official form of health care, and it does not constitute the total health care delivery system. Looking at South Africa alone there is a lot of the official health care supply, of which African traditional care is one of them (Van Rensburg et al., 1992: 313).

3.2.4 Inclusion of Traditional Health Care Service

Traditional health care has been in existence in all cultures as an independent health care system alongside the officially established system. But one may conclude its history of existence as that which is as older as oneself. There is a clear and widely spread skepticism, if not hostility amongst modern or scientific health care practitioners regarding traditional health care system. Traditional medicine, especially in most African countries, has been seen as a closed system. It was only the scientifically orientated western culture that has been seen as an open system with a highly developed awareness of alternative explanations of causes of diseases (Staugard 1985: 68).

In the ninth declaration of Alma-Ata the World Health Organization in conjunction with other health ministries, gave a mandate that, all governments should formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it would be necessary to exercise a political will, to mobilize the country's resources, and to use available external resources rationally (Stanhope & Lancaster 1992:36).

This brings us to the seventh point of the seventh declaration which states that, "relies, at local and referral levels on health workers, including physicians, nurses, midwives, auxiliaries, and community workers, as applicable, as well as on traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community" (Stanhope & Lancaster 1992: 37).

It would be very irrational for the Ministry of Health to totally ignore the need for the inclusion of traditional health care delivery system towards the goal of achieving health for all citizens of the country. Many authors are recently conceiving or internalizing a new school of thoughts. They now realize that the idea of defining traditional medicine as a primitive or a closed system is false. This is because there is a clear indication that traditional healers' representing a relatively open system, free to adapt to people's perceptions and needs with a holistic framework (Staugard 1985: 68).

Bellakhdar (1989) reflects on factors that make traditional medicine to survive as follows:

- It is a practical art, well, and rooted in the local cultures, and the relationship between the patient and the therapist is simple and closed.

- The remoteness of the rural areas from official health centers helps treating a certain following for traditional medicine, which is always represented locally by a practitioner, even if he/she sometimes earns his/her living at another occupation. The sedentary and urban-centered nature of modern medicine is thus a factor that militates in favour of traditional practitioners.
- Care is very often given in patients' homes. The best-known example is that of traditional birth attendants who look after mothers in their homes, but there is also many *fugaha* who are willing to visit their patients on their sickbeds, wherever they may be.
- There is special proximity, which is conducive to the practice of family medicine because usually in a traditional family there is one member who out of wisdom or experience has a store of simple remedies and directives for collective hygiene and prevention. This brings an immediate gain to the family from the availability of this non-professionalism.
- Traditional therapy remains on the whole a soft type of medicine, using treatments that are mainly oral or topical and very rarely draw blood. This makes it easier for patients to accept the treatment.
- Lastly, ancient forms of medicine have magic or religious aspects that exercise a powerful sway over people's minds.

3.3 THE HISTORICAL BACKGROUND OF TRADITIONAL HEALTH CARE IN SOUTH AFRICA: 1652 TO 1910

3.3.1 Introduction

Though the actual documentation of the history of health care in South Africa is dated as far back as 1652, traditional medicine was already in existence. This is so because there was never a vacuum as far as health care is concerned. It becomes clear that some form of indigenous practices had

been utilized by the indigenous/traditional people of the time (Van Rensburg et al., 1992: 36).

3.3.2 The Settlement Period: 1652-1795

This was a period of great discovery that was geared at a transition from indigenous/traditional medicine towards modern scientific medicine, which took place in the Cape, following the Dutch rule and its influences. During this period some of the strong remnants of ancient beliefs and customs like witchcraft "vhunanga" in Venda, blood letting (cupping which is "ulumea" in Venda) and quackery were still practiced. In 1657 settlements of the burghers came into being. This was the time where the Cape had developed into a permanent European community. At that point and time there were a first private practitioner and a civil surgeon (one Jan Velteman) who appeared to practice health care amongst the free burghers were there. On the other hand another development was that of the indigenous medical system, expertise and herbs of the "khoikhoi" which were used, forming the background or the folk medicine of the white settlers. Due to the fact that there were very few medical aids, migrant farmers in the Cape developed a unique pattern of folk medicine and self-care. They used medicinal plants and herbs. Towards the end of the 18th century a number of trends were perceptible with regard to the emergent health care system. For example, to mention one such trend, there was a very strong component of quackery, folk medicine and traditional medicine, which were practiced side by side with the then still emergent professional, western and scientific medicine (Van Rensburg et al., 1992:36-40).

3.3.3 The Period of Expansion, Consolidation and Control: 1795-1910

This was a period of colonization of the country by the British, which started from the Cape then moved eastwards and northwards until the entire South

Africa was under British rule. The British rule also had a great influence on health care, which was manifested in the actual structuring and control of health care (Van Rensburg et al., 1992: 41).

3.3.3.1 Health Care legislation and Official Control Structures

It was during 1806-1807 where an inquiry into the state of health services at the Cape was launched. This brought forth the first legislation of health care in South Africa, and the establishment of the supreme Medical Committee to control health matters. The legislation aimed at licensing medical practitioners with the idea of cracking down on quackery in mind. It was during this time that the first list of approved practitioners was officially published in the Supreme Medical Committee after careful scrutinization of certificates. This made it clear that indigenous medical practitioners were not listed due to the fact that they did not have formal training that provided them with a certificate.

In the Free State province, the first care legislation was promulgated only in 1864 by the National Assembly of this Boer republic. The act stressed that neither doctor nor surgeon would be given the license to practice unless the person produces a European diploma or proof that he/she had a license to practice in the Cape. This never stopped nor crippled quackery and other irregular practices to flourish (Van Rensburg et al., 1992: 41-43).

3.3.4 Development in the Healing Profession

This became the second period of developments in medical and related services in South Africa, characterized by increased legal control and professionalization of health care. This further sharpened the distinction between professional medicine on the one hand and folk medicine and quackery on the other. Nurses arrived on the medical care scene of South

Africa later than doctors; they only started to appear in the last quarter of the 19th century. It became very obvious that prior this period, folk medical nursing was long in existence, practiced by Voortrekkers and rural communities. This type of nursing spread widely all over the country. The following were amongst other patent remedies and veld medicines utilized during the 18th century for any imaginable ailment. These included a series of plants and herbal remedies and others containing animal material.

In the preparations of the above remedies, it is so interesting that experience, common sense and superstition were used. Furthermore traditional birth attendants called Aoutantes were also available. Traditional communities of that time commanded accurate knowledge of plants and their characteristics. Herbalists from different tribes used the same plants, often with different names for the following reasons: to expel worms, to induce vomiting, for purging, or to treat snake bites, dysentery, ringworms, lumbago, malaria, fever and other symptoms. The different medicines were inoculated, applied externally, inhaled or chewed after being fumigated, carbonated, powdered or infused (Van Rensburg et al., 1992: 50).

3.3.5 The Role of Traditional Healers in South Africa

For many decades health care planners in South Africa, ignored the major role of traditional healers in the lives of most South Africans. This exclusion became embedded in the apartheid ideology, and even in the recent period of the post apartheid context (Freeman & Motsei 1990:1).

3.3.5.1 Summary of Traditional Healers and Medicine

Traditional healers in South Africa, can be classified into three broad categories,

(a) Traditional Doctors, (Herbalists or Nanga in Tshivenda)

This is usually a male who specializes in using herbs and some other medical treatment, like mixtures of animal origin to treat diseases. Most of these healers turn to specialize on some selected health conditions.

Calling, Training and Activities

Usually the person may decide to be a herbalist or may be chosen by a family member who is practicing. A family member often a father, mother or any of the grannies usually does training in the house, for a period of a year or less. In their training they are taught to depend on the patient's signs and symptoms in order to come up with the appropriate treatment. At the end of training the new diviner pays his master a cow of which nowadays money is calculated which is equivalent to a cow. Now, the new traditional doctor (Nanga) can now pass it or to one of his sons who shows signs that he likes medicine. Usually they do not use bones to detect problems or illnesses (Freeman and Motsei 1990: 1; Blackett-Sliep 1989: 42 - 43 and Troskie 1995: 18 - 19).

(b) Diviner (Sangoma in Tshivenda)

This is usually a woman who qualifies after undergoing the (U thwasa) process. She operates within a religious, and or supernatural context.

Calling, Training and Activities

Usually one has to be called by the ancestral spirits to become a diviner. This time the person does not choose to become a diviner, but is bestowed upon her clairvoyant powers. A qualified diviner to whom she is apprenticed for some time teaches the neophyte many

things on medicine. Though at other instances some of the medicines will be revealed by her ancestors either through a dream or a vision. Due to ancestral influence, the person on training has to abstain from certain things.

(c) Faith healers / prophets

Faith healers actually indicate syncretism, a reinterpretation of orthodox christianity in such a way as to be reconcilable with traditional culture.

Calling, Training and Activities

They may be trained in an institution like a biblical college, technikon or university as well as in some churches. But first of all, one has to have a calling from God.

3.4 THE CULTURAL CONTEXT OF HEALING, ILLNESS AND MEDICINE

Traditional medicines have been treated as a subculture in many societies, that is, it has been generally considered a group within a lager group. Health care professions also formed subcultures, for example, if one decides to become a doctor he or she will be obliged to learn not only a new vocabulary, but will acquire a new way of seeing, that goes within that vocabulary of which it is the same with traditional healers. Traditional and modern health systems seem to be marginal in nature because each has little to do with either of the other group (Loustaunau & Sobo 1997:10-13). The link between cultural context, healing institutions and human behaviour related to illness and help seeking can be well understood by studying the various elements of cultures for example:

3.4.1 Ethnocentricity

Ethnocentricity involves using one's standards, values and beliefs to make judgements about someone else. This is always common with modern health services over traditional health services. The modern health system condemns the customs, ideas, behaviours, values and beliefs of traditional health systems because they differ from their own (Loustaunau & Sobo 1997: 14).

3.4.2 Medicocentric

Medicocentric view focuses on diseases identified through signs and symptoms without considering the patient's perception of problems surrounding his/her illness. This view makes health professionals to ignore patients' views regarding their problems. Medical professionals continually exhibit both ethnocentric and Medicocentric attitudes in their daily activities. A medicocentric doctor as a product of his own medical training culture usually uses a reductionist model, which attempts to diagnose patients by reducing their problems to medically explained phenomena. But patients in their own right may attempt to expand and relate the problem to their own perceptions and experiences such as an inability to carry out daily functions, misfortunes and discomfort (Loustaunau & Sobo 1997:14).

3.4.3 Cultural Relativism

Cultural relativism requires that people should not judge others, but should consider actions, beliefs or traits within others' cultural contexts in order to understand them. It involves maintaining a sense of objectivity and appreciation for the values of other cultures. Cultural relativism does not look at how bad or how good cultural elements are but look at them as just different. The only problem with cultural relativism is that some of the cultural

elements could be highly detrimental to human lives, for example, in the Tshivenda culture women are taught the idea of stretching the labia minora at the same time destroying the hood of the clitoris. This practice usually destroys the clitoris' erotic zone, so that females will not become sexually active or desirous and will remain virgins until marriage and will be faithful afterwards (Loustaunau & Sobo 1997:16).

Another example is of a child who develops a red mark below the occiput at birth. This redness makes the old ladies suspect to present of "gokhonya". "Gokhonya" as they say is characterized by white patches on the vulva of the mother distributed like a map structure. As soon as the redness on the child is noticed the mother is taken to an appropriate "nanga" specifically a woman, who would use a razor blade to cut off all those marks on the vulva. This pre-disposes the woman to great blood loss and potential genital infections. Both examples clearly show that cultures do differ, what is illness to one person or culture may be of no significance to the other, and vice versa. Another example of cultural differences is what may be classified as mental illness in some other cultures may not be classified as illness in other culture, but interpreted as a favour from God in allowing that individual to understand and see what others cannot. In the Navajo tribe, congenital hip disease or dislocation is highly prevalent resulting in people limping, but treatment is simply not seen as necessary although at times it could be painful. The idea that the affected person is limping is not a stigma in the Navajo society (Loustaunau & Sobo 1997:18).

3.5 THE HEALTH RELATED CONSEQUENCES OF SOCIAL STRUCTURE TOWARDS DELIVERY AND UTILIZATION OF HEALTH CARE SERVICE IN A MULTI-CULTURAL SOCIETY.

Much of the tension in the clinical encounter does not derive from the existence of diverse health subcultures, nor is due to a failure in medical education to instill an

appreciation of folk models of health and illness; rather, it is a reproduction of larger class, racial, and gender conflicts in the broader society (Loustaunau & Sobo 1997:21)

The social structure is another environment into which interactions of human beings take place focusing on value, beliefs and behaviour patterns. At times people disregard others' definitions and perceptions of health and illness because of failure to acknowledge the socio-cultural factors which influence those behaviours and interactions. This brings home the idea of considering, not only culture but also the social structure which depicts why people behave in a certain way or do things in another way (Loustaunau & Sobo 1997: 21).

3.5.1 The Family

It is of no use for health professionals to ignore the ideas of family because it is out of this social unit that beliefs originate. It is out of this unit that a hidden health care system had been in practice for ages. Due to this link between family members there would be a continuous interruption when they think other alternatives of health care should be instituted (Loustaunau & Sobo 1997: 24).

3.5.2 Ethnicity

Ethnicity is tied to notions of shared origins and shared cultures. Some ethnic groups can be a minority so such that they may lack the opportunity, access, and participation in any health set-up. At times clients do adhere to medical recommendations such as taking medication because of fear that they will be poisoned. Many link black-fears about white professionals' intention to kill them in order to reduce their number. This historic notion is even detrimental to our own folks today. They find it so difficult to consult with white doctors,

let alone admission to a strange environment-the hospital (Loustaunau & Sobo 1997: 28-32).

3.6 THE INTERNATIONAL PERSPECTIVE ON TRADITIONAL MEDICINE

3.6.1 Aboriginal Australian Traditional Medicine

To the Australian aborigines, the tea tree has been the medicine of their choice to treat bruises, insect bites and skin infections. Studies proved that the tea tree oil has antiseptic as well as activating effects on white blood cells differentiation qualities. This conclusion confirms the fact that herbal tea may influence the body's immune system (Budhiraja et al., 1999).

3.6.2 Ethiopian Ethnic Tradition

According to Erlandsson & Backman (1999) a fourteen-year-old Ethiopian girl who was done dental mutilation by a medicine man at the age of three, had continuous stomach problems. It was after these mandibular primary canines extraction that her tooth germs of the Succedaneous teeth got damaged and resulted in permanent canines' deformity. All these problems were associated with the action of the medicine man.

3.6.3 The Nigerian Traditional Perspective

3.6.3.1 Anti-Diabetic agent

The leaves of Mngifera indica are used as an anti-Diabetic agent in the Nigerian folk medicine. Following the study, which was conducted, the outcome revealed the fact that these leaves possess hypoglycemic activity.

This effect is due to the fact that the leaves have intestinal glucose absorption reduction (Aderibigbe, Emudianughe & Lawal 1999).

3.6.3.2 Antifungal and antimicrobial agents

In another study Zygotritonia crocea and the leaves of Spondias mombin respectively could achieve the antifungal as well as antimicrobial effect. These plants exhibit a wide spectrum of antibacterial effect as those of Ampicillin and Gentamycine. The antifungal effect of extracts of Zygotritonia crocea Croton zambesicus were also comparable to those of Tioconazole (Abo, Ogunleye &Ashidi 1999).

3.6.3.3 Laxative and oxytocin agents

The use of ethanol extract of Diodia scandens helped the Nigerian traditional healers in the treatment of constipation as well as in the induction of labour. It is also suggested to help in enhancement of erection and ejaculation in males, hence its regular use by some elderly males (Onuaguluchi & Nwafor 1999).

3.6.4 Treatment of the ulcer

Anti-ulcer activity of four medical plants, Diodia sarmentosa (whole plant), Cassia nigricans (leaves), Ficus exasperata (leaves) and Synclisia scabida (leaves), which are commonly used by the Nigerian traditional healers for the treatment of peptic ulcer were investigated. After acute toxicity tests were done, the results revealed good results of anti-ulcergenic effect. When these plants were tested on rats, they protected them from:

- Aspirin-induced ulcerogenesis,
- Delayed intestinal transit, and

- Increased pH and decreased both the volume and acidity of gastric secretion. (Akah, et al., 1998)

3.6.4 The Traditional Health Experience in China

3.6.4.1 Diabetic agents

A range of traditional medications proved to be anti-hyperglycemic. This constituted five crude drugs of Byakko-ka-ninjin-to. These drugs are (ginseng, anemmarrhena, -licorice, gypsum and rice (Kimura et al., 1999).

3.6.5 The Ugandan traditional perspective

3.6.5.1 Anti-Malaria agents

Looking at the fact that the mortality and mobidity statistics which appear to be too high in South Africa, many Africans now tend to rely on herbal medicines as the first line of treatment. "Anti-Malaria Agents" appear safe though not always tolerable. The effects of this Ugandan agent resulted in the reduction of Malaria parasites count in-patients taking "Anti–Malaria Agents" (Wilcox 1999).

3.6.6 The South African Perspective

South Africans, like other nationalities, are not immune from the practice of using plants for healing. Traditional medicinal plants contribute significantly to primary health care. A study has been conducted in the Eastern Cape where the following plants were revealed by traditional healers and rural dwellers, namely Grewia occidentallis, Polystichum pungens, Cheilanthes viridis and Malva parvifolia. These plants are commonly used for the

treatment of wounds in the province. The study confirmed the fact that the plants generally have antibacterial properties, hence their good effect on bacterial contaminated wounds (Grieson & Afolayan 1999).

3.7 SUMMARY

Indeed there is a great need for a multicultural orientation because each culture may learn from the other resulting in adaptation, modification, incorporation of techniques and philosophies for the survival of humankind (Laustaunau & Sobo 1997:143).

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The aim of this investigation was to examine the extent to which traditional healers, health practitioners and consumers collaboratively contribute towards the attainment of health for all in South Africa. To address this question, a research process was developed.

4.2 RESEARCH DESIGN

According to Lobiondo-Wood and Harber (1994), the research design is influenced by both the research objectives and the conceptual framework. As Polit & Hungler (1993) state, this process entails the gathering of analyzing of data. Paying attention to details that influence validity and reliability of the research findings.

4.3 RESEARCH QUESTIONS

The main research questions were as follows:

(i) To what extent do health practitioners' appreciate and understand the traditional healing system?

(ii) How do health institutions integrate traditional healing systems?

(iii) How can collaboration of the two health systems (traditional and modern) be realized?

4.4 TARGET GROUP.

Table 4.1

Northern Province Population Census

TOTAL POPULATION	MALE	FEMALE	FEMALE PERCENTAGE
4929368	2253072	2676296	54,3%

The higher percentage of male counterparts working in the South, where most industries are found is common. Community members who reside in the Northern Province were targeted. There were no data that existed regarding the total number of traditional healers who were practicing in the Province. It should be said that South Africa does not have the existing data about traditional healers. The rationale is that some of the traditional healers operate covertly. It is inevitable, therefore, to choose only the group that is overtly practicing traditional healing.

The health care practitioners at the Nzhelele Tshipise area would be the target population. Three-target population has been chosen to participate in the study:

(i) Traditional healers - delivering services in Region 4.

(ii) Health professionals - practicing at Siloam hospital as well as at its clinics.

(iii) Health care consumers - utilizing health care services rendered at Siloam hospital and its clinics.

4.5 SAMPLING PROCEDURES

The sampling was incidental and purposive, for traditional healers, health professionals who were on duty on specific days and health care consumers who came on specific days. The researcher selected those participants during an

interdisciplinary meeting of herbalists, healers and community health nurses. A non-probability endeavour was essential because as stated earlier, there is no database or directory of traditional healers.

4.6 INCLUSION CRITERIA

Traditional healers included were those rendering their services in Region 4. Health professionals included those rendering direct patient care either in the hospital or at clinics. Health care consumers were those actively utilizing either or both health care services. The shortcomings associated with this sampling process were as follows:

- Not every person in the target population had an equal opportunity to be selected;
- Representivity was compromised.

The roles and activities of the traditional healers and the health practitioners were taken into consideration.

4.7 SAMPLE SIZE

The health professionals were affiliated with the following institutions:

(i) hospital
(ii) clinics and the
(iii) health centres.

The participants were interdenominational. This characteristic seemingly compensated for the racial imbalance, which was inevitable. It was not the result of

selection bias, and it merely reflected the South African situation. Incidental sampling that has been used had the following advantages:

- economical viability;
- simplicity;
- convenience;
- reasonableness; and
- relevance.

Since the sampling process was purely by incidental, only those participants who would be on duty and available at the health institutions would be picked randomly and constitute the sample. The researcher intended to hand-pick at least 90 participants categorized as follows: 30 traditional healers, 30 health professionals and 30 health care consumers.

4.8 RESEARCH SETTING

The research was conducted in the Northern Province, composed of the three former Bantustans: namely, Venda, Lebowa and Gazankulu. These neighbourhoods are relatively homogenous in terms of race, due to the historical dynamics of separate settlements. The area consists of areas that may fit the following descriptions:

Table 4.2

Areas of Region 4

AREA/LOCATION	HOSPITAL	CLINIC/HEALTH CENTER
Nzhelele	Siloam	Clinics/ Health –Centres
LouisTrichardt	LouisTrichardt	Clinics/ Health –Centres
Thoho-ya-ndou	Tshilidzini	Clinics/ Health –Centres
	Hayani –Herberg	None
Elim	Elim	Clinics/ Health –Centres

Siloam hospital and its clinics became the area of concentration for the research study.

4.9 CLIMATIC CONDITIONS

The Northern Province has a tropical climate. It is located alongside the Tropic of Capricorn. Occasionally there is an abundant of rain, but it tends to be dry and extremely hot. It is saturated with rich vegetation. It is mainly agricultural, producing most of the country's food. However, it is also regarded as one of the poorest provinces of South Africa. There are no big industrial complexes. Most income generating projects are small and individually run.

4.10 DATA COLLECTION TOOLS

The data collection instrument was first administered to 15 participants for the purpose of testing and refining the questionnaire items. Participants who took part in the pre-testing process were eventually excluded from the main research project.

4.10.1 Open-ended Question Items.

Question items were read to participants who were illiterate. They had the advantage of adding or substantiating, as they wished.

4.10.2 Closed-ended Question Items

These questions needed participants to respond by either saying yes or no which limited their comments on the issues.

4.10.3 Observations

Traditional healers and consumers who couldn't read and write were both observed in the three setting and interviewed by the researcher who later transcribed all information. Health professionals, traditional healers and health care consumers who could read and write felt uncomfortable to complete their questionnaires in front of the researcher. The reason offered was that they wanted their responses to be treated confidentially.

4.10.4 Review of Documents

Relevant documents were reviewed. There were limited databases on traditional healers in MEDLINE and SABINET, which were located at libraries, clinics and office of the Democratic Nursing Organization of South Africa.

4.11 VALIDITY AND RELIABILITY

Impingement of personal bias was excluded as much as possible. As Polit and Hungler (1993) state, the degree of consistency of any instrument in measuring any

attribute. To augment the validation process, a pilot study was conducted. Reliability, as described by Polit and Hungler (1993: 244) is when the instrument is consistently measuring the attributes. The authors continue to suggest confirmability, to reinforce validity and reliability.

4.11.1 Translation

The questions were translated into Tshivenda for those participants who could not understand English. The health practitioners' questionnaire was not translated and they completed it on their own.

4.11.2 Confirmability

Confirmability refers to objective assessment by an external assessor. These evaluators were given a chance to critique the data and determine the degree of relevance or meaning. Those participants who could read were given an opportunity to peruse to their satisfaction the letter of intent (see Appendix A). The researcher assured the participants that the data collected would be used for the purpose of the study only.

4.11.3 Credibility

The data collected would be a true reflection of what transpired during fieldwork. The additional time that was spent with all the participants was important. During this period the researcher became better acquainted with the expectations of the research study.

4.11.4 Pilot study

Siloam Hospital, which is located in Nzhelele Tshipise, was the setting for the pilot project. Interviews were held with fifteen participants. The following is the sample for the pilot project:

Table 4.3

Number of Participants

PERSONNEL	CATEGORY	NUMBER	PERCENTAGE
Hospital Personnel	Physicians	1	6.6%
	Nurses	2	13.3%
	laboratory	1	6.6%
	technicians	1	6.6%
	Physiotherapist		
Traditional Healers	Sangomas	2	13.3%
	Divine healers	1	6.6%
	Faith healers	2	13.3%
Health Consumers	Teachers	2	13.3%
	"Lay people"	2	13.3%
	Retired policeman	1	6.6%
Total		**15**	**100%**

The pilot study was conducted concurrently with the pretesting of the questionnaires. The process of data collection for the pilot group took three consecutive days and continued for eight hours a day. The instrument was translated into Tshivenda. During this process, the researcher discovered how to establish rapport with the traditional healers.

Certain rituals were inevitable, like the fact that traditional healers cannot just be interviewed informally. The researcher had to identify herself first through the gatekeeper. The interview took place after all participants got acquainted with the exact nature of the investigation. It was shown under

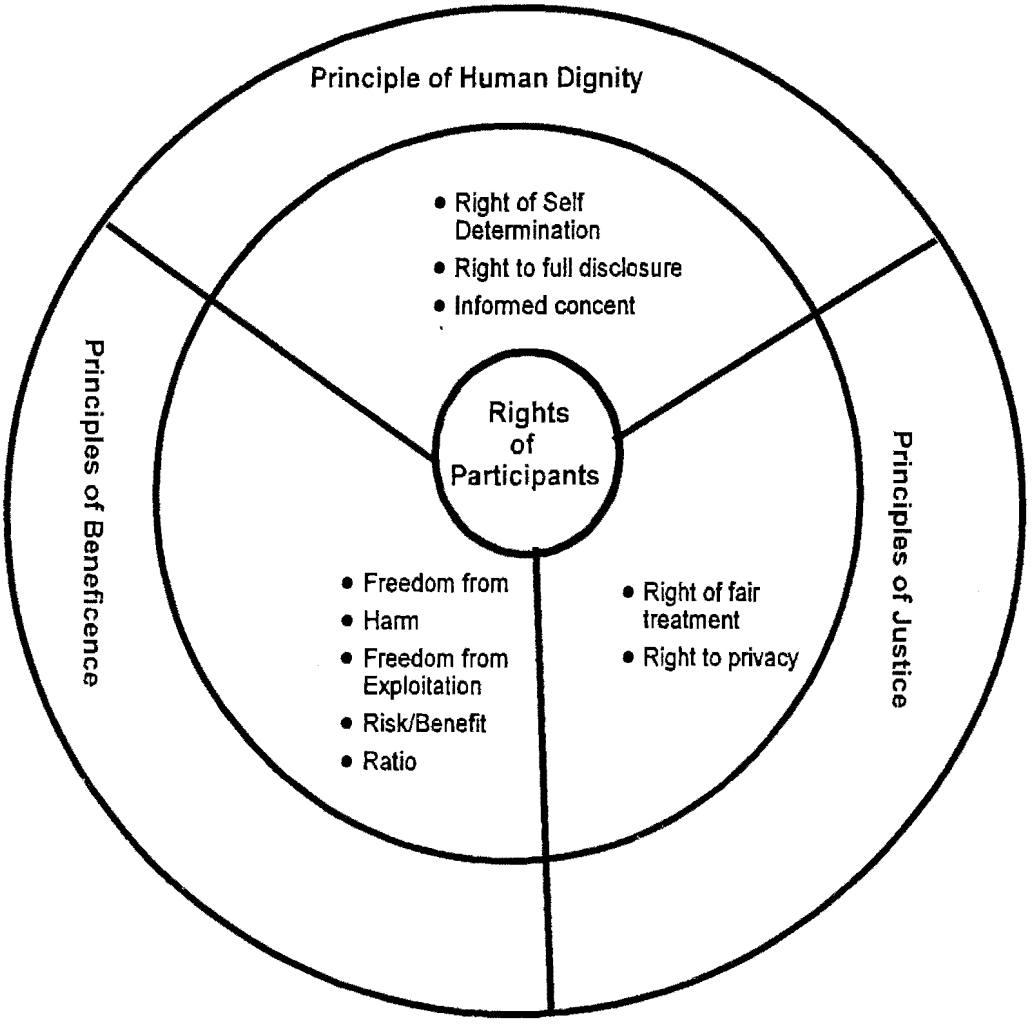
ethical concerns that a detailed explanation was given, based on the findings of the pilot project.

4.12 ETHICAL CONCERNS

The right of the participants had to be protected. The diagram below facilitated the researcher in her discussion of ethical principles.

Figure 4.1.

Ethical concerns



4.12.1 Principles of Beneficence

As one of the fundamental ethical principles in research it includes:

(a) Freedom from Harm

The participants were not exposed to either physical or psychological harm. There was no harm whatsoever, that needed the calling off of the study, because no instruments were used in the study nor exposure to environmental hazards. Participants were allowed to ask questions where it was deemed necessary and were also given the researcher's address in case they might need to contact her.

(b) Freedom from Exploitation

Participants were given full assurance in the debriefing session that their identities are protected and would remain anonymous. This became so important because it was not so long ago that a woman, who gave full details about her being abused by the husband, ended up killed because the person who gathered the information shared it with a friend until it eventually reached the husband. Again during the researcher's field study it was discovered that some of the health professionals liked the idea of visiting traditional healers for some reasons known to them, but they wanted their privacy to be kept a secret.

The researcher clearly stated her position to the participants regarding time, days to be used and well placed of rendezvous. The idea was that the researcher needed to contact all participants at their convenient places like the hospital for health professionals, homes

and working environments for consumers and homes for traditional healers.

(c) Risk/Benefit Ratio

It was very important that the risk benefit ratio be considered. The researcher made it clear to all participants that the benefit of the study would be more than the risk because the outcome of the study would benefit the society and increase the body of knowledge in the medical profession.

The bottom line is that the extent of the risk on the informants should not exceed the benefits of new knowledge gained. To ensure an acceptable risk/benefit ratio the researcher made sure that she kept a strong focus on the significant topic, having the potential to improve consumer health care (Polit and Hungler 1993:357).

It is obvious that all research studies do have some risks, but this should be minimal. *Minimal Risk*, according to federal guidelines, is identified as anticipated risk that are not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological tests or procedures. Polit and Hungler (1993: 358) drew up the following box, which clearly identifies major potential benefits and major potential costs or risks to the informants.

Potential Benefits and Costs of Research to Participants

Major Potential Benefits

- Access to an intervention to which they might otherwise not have access.
- Comfort in being able to discuss their situation or problem with an objective and nonjudgmental researcher
- Increased knowledge about themselves or their conditions, either through opportunity for introspection or through direct interaction with the researcher
- Enhanced self - esteem resulting from special attention or treatment
- Escape from normal routine, excitement of being part of a scientific study, and satisfaction of curiosity about what is like to participate in a study
- Knowledge that the information subjects provide may help others with similar problems or conditions
- Direct monetary or material gains

Major Potential Costs

- Physical harm, including unanticipated side effects
- Physical discomfort, fatigue, or boredom
- Psychological or emotional distress resulting from self – disclosure, introspection, fear of the unknown or interacting with strangers, fear of eventual repercussions, anger at the type of questions being asked, and so on
- Loss of privacy
- Loss of time
- Monetary cost (e.g., for transportation, baby - sitting, time lost from work, or charges for additional procedures and tests associated with the research)

Source: (Polit and Hungler 1993: 358).

4.12.2 Principle of Respect for Human Dignity

This principle includes:

(a) Right to Self Determination

It was of great importance that the researcher established a good relationship with her participants, taking into consideration that every one of them did receive full respect and trust. They were all treated as autonomous agents, capable of controlling their own activities and destinies. Participants were allowed voluntarily participate in the study or not to participate in the study, without the risk of incurring any penalties or prejudicial treatment. Again participants were given the right to terminate their participation at any point of the research process or refuse to give information, or to ask for clarification about the purpose of the study or specific questions (Polit and Hungler1993: 358).

(b) Right to Full Disclosure

The researcher acknowledged the principle of human dignity and respect, which involves people's right to make informed voluntary decisions about their participation in the study. Full disclosure of the nature of the study was made to all participants. Clarity was made regarding the fact that no person would be intimidated nor given any prejudicial treatment in case he or she needed to withdraw before or during the research process. Mention was made to participants that information disclosure would continue throughout the study process, in case there was a need for clarity, and that there is freedom of choice regarding participation (Polit and Hungler 1993: 359).

(c) Informed Consent

The researcher had provided the participants with a letter before engaging in any activity of the research study (see appendix A). This exercise was made in order to allow individuals to make an informed decision of whether to participate in the study or not. The researcher took into consideration that human beings are autonomous agents who are capable of controlling activities they need to involve themselves into.

4.12.3 Principle of Justice

(a) Right to Fair Treatment

All participants regardless of their status or social position were treated equally and with respect throughout the study regarding the following:

Any agreement made would be adhered to like, giving of money or awards etc.

- Participants' access to professional assistance in case of any psychological, emotional or physical damage during the study process was negotiated
- No prejudicial treatment was given to the participants in case they decide to withdraw their activities.
- Free access to the researcher by the participants for clarity would always be accepted (Polit and Hungler 1993: 362).

(b) Right to Privacy

Due to the possibility of intrusion into the lives of participants, the researcher did ensure that the research is not more intrusive and that privacy was maintained at all cost throughout the study process to ensure human dignity. Confirmation was made about the data collected that it would be kept in the strictest confidence. The participants could not be linked with their information that was the reason why they were treated with anonymity (Polit and Hungler 1993: 363).

4.13 SUMMARY

In conclusion one is tempted to say that, out of the methodological processes the topic still needs continuous assessment/investigation. This is so because during the researcher's data collection period, traditional healers revealed other concerns like, "neck–lacing" of some of the traditional healers due to the fact that the new generation regards them as witches. They also talked about freedom, which is of destruction, because women do cut trees freely without consulting the old ladies, which results in destruction of herbal medicinal trees. All in all the study revealed the need for inclusion of anthropology in a professional health curriculum, for health professionals to can understand cultural diversities and their influence on health delivery services.

CHAPTER FIVE

DATA ANALYSIS

5.1 INTRODUCTION

In this chapter we are focusing on data analysis, interpretation and narratives of the research findings. The two research designs were blended; namely, qualitative and quantitative data analysis, which generated two corresponding types of data. The data were collected using three types of related questionnaires, about traditional healers, health care consumers as well as health care professionals. The first section of the questionnaires dealt with the demographic profile of the participants and is analyzed using quantitative analysis.

- **Data display**

  There were three phases used in the data analysis process. Initially, the most laborious phase described by Miles and Huberman (1994) as data display involved transcribing all the data in full. The intention here is to ensure that all the data that is gathered is seen in its entirety. According to Carnwell (1997:126) this to ensures that the process is manageable. Researchers must avoid lengthy interviews and observations, and large sample sizes.

- **Data reduction**

  Subsequently, the data has to be reduced. This process is meant to eventually remain with smaller relevant and manageable data to facilitate comprehension and easy identification of existing patterns in the data.

❖ **Data interpretation**

The common concepts were all identified and linked together to devise categories.

5.2 TRADITIONAL HEALERS

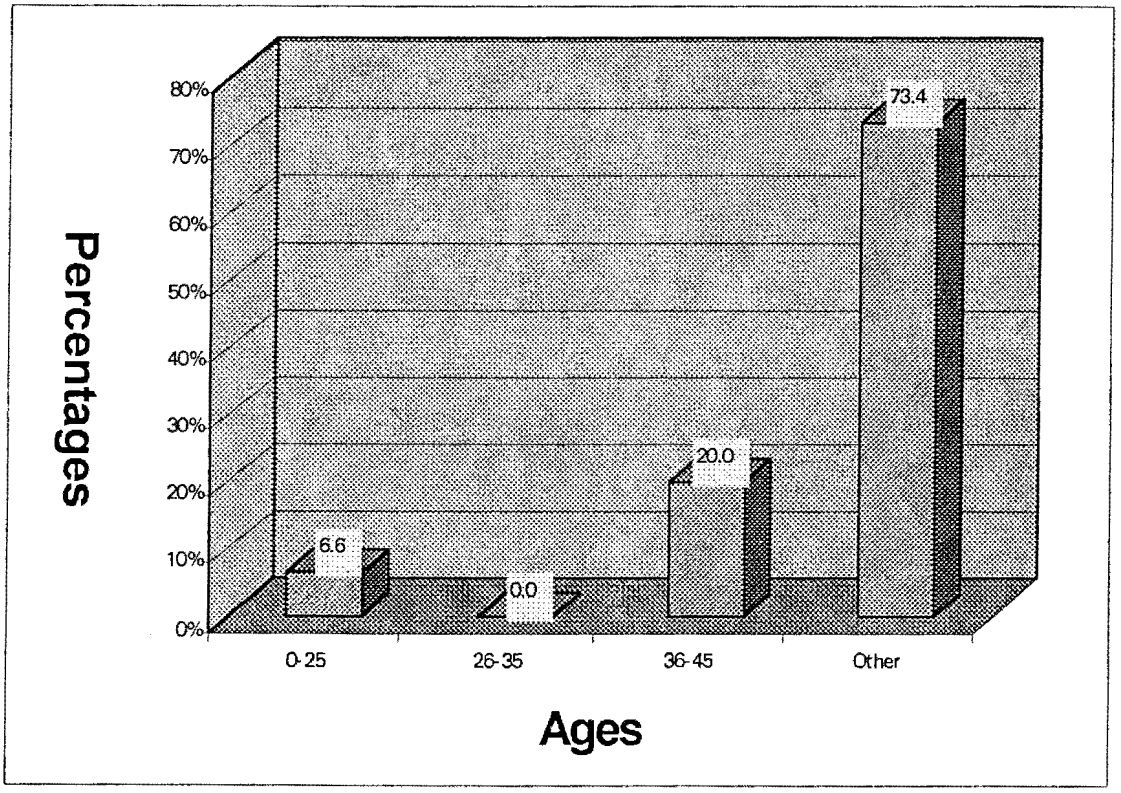
5.2.1 Quantitative Analysis

❖ **Demographic information**

Item 1: Age

Figure 5.1.

Age distribution of traditional healers

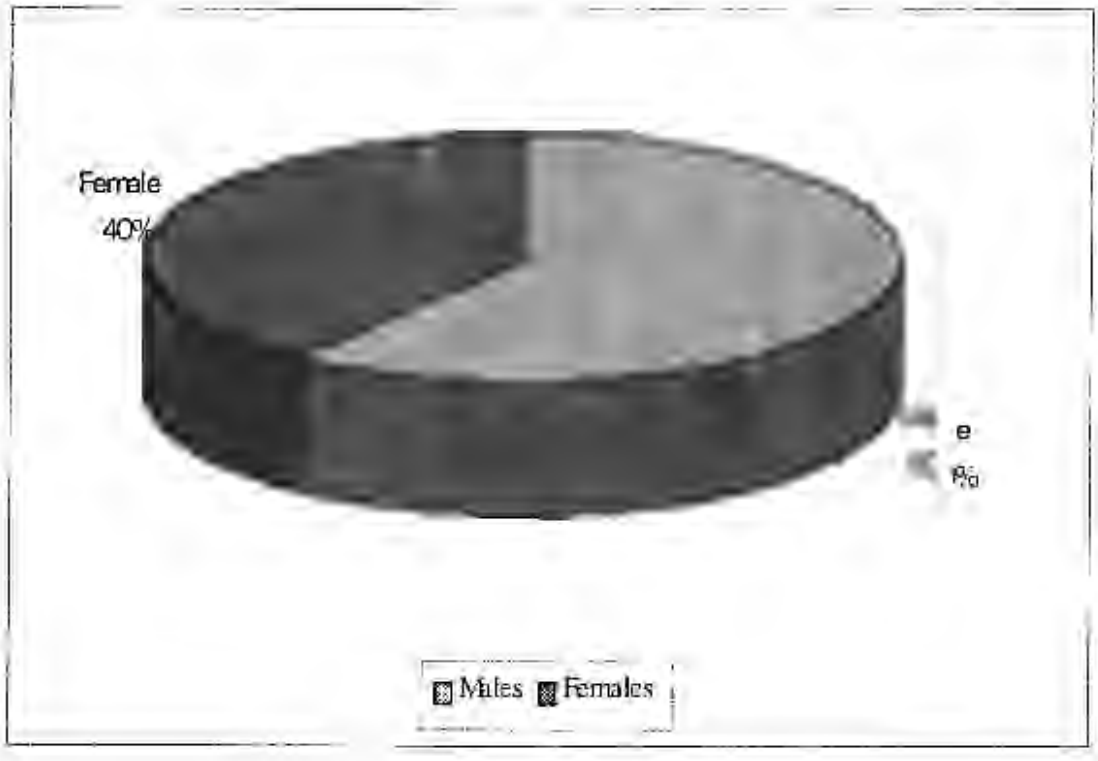


About seven percent (6.6%) the traditional healers ranged between 0-25 years. None were between 26-35% years old. For the age range, 36-45 years it was 20%. The majority (73.4%) were above 45 years old. This implies that the characteristics of the traditional healers who were interviewed were above middle age. This might also suggest that age and experience might be a factor in qualifying for the role of being a traditional healer.

Item 2: Gender

Figure 5.2.

Gender of traditional healers



The sample constitutes 40% females and 60% males. In modern health care setting, usually males are dominated by females whereas in the traditional health care setting the sample reflects female dominance.

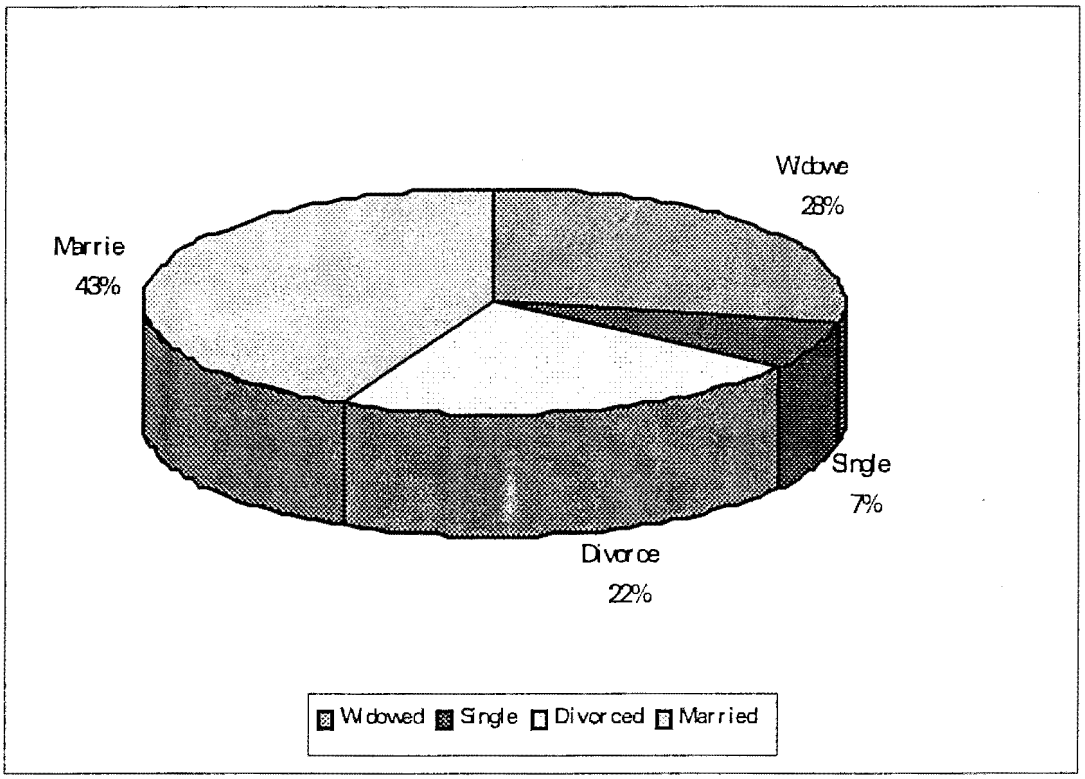
Item 3: Race

All traditional healers who participated in the study were black South Africans. Looking at medical practitioners, most doctors in the study were from different countries, for example, Cuba, Holland and Britain, which may suggest that, South Africa is still running short of doctors. Furthermore, doctors' population is composed of a high percentage of whites. This is a typical culturally bound type of a setting, except that some whites had entered the traditional system, for example, Rae Graham, a retired traditional healer (Thailia Elisis 1995:39).

Item 4: Marital status

Figure 5.3.

Marital status of Traditional Healers

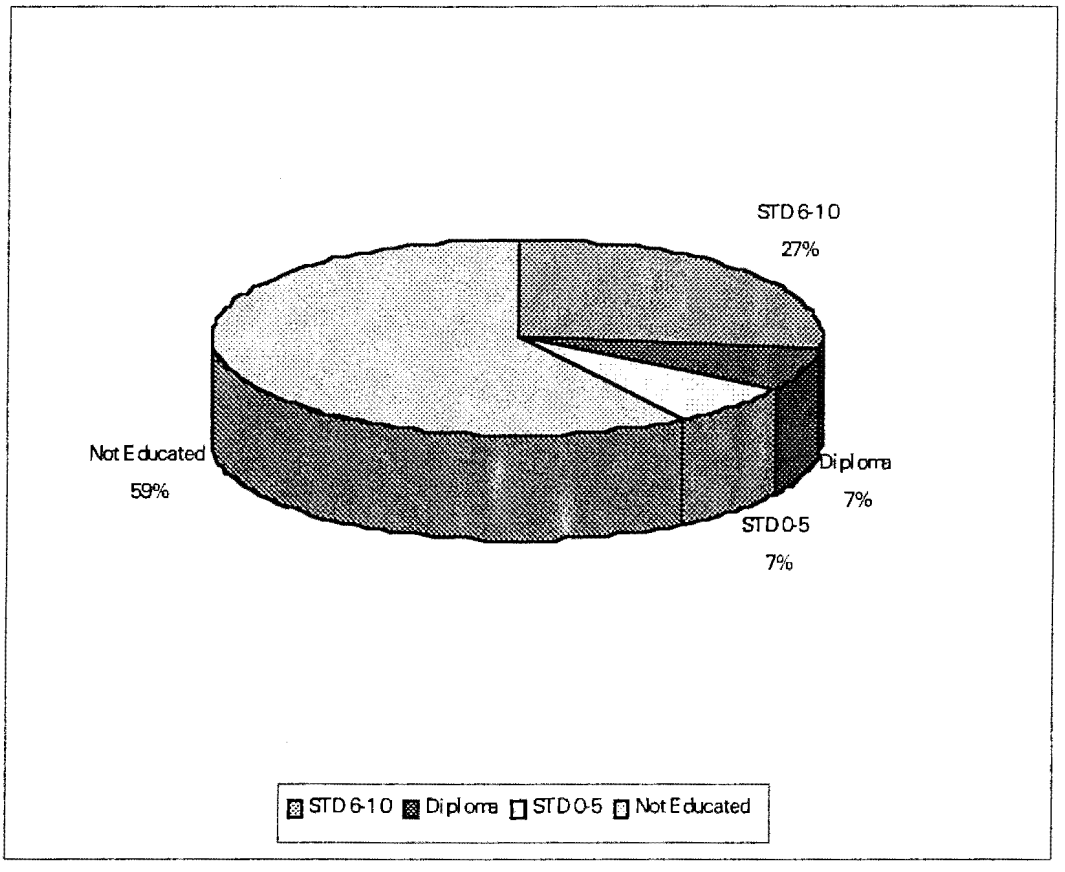


Of the traditional healing participants, 43% were married, 28% widowed, 22% divorced and 7% single. This sample of traditional healers manifested the idea that most of them did marry at one stage or another, and this formed the majority (93%) of the total number of participants.

Item 5: Educational Level

Figure 5.4.

Educational levels of traditional healers



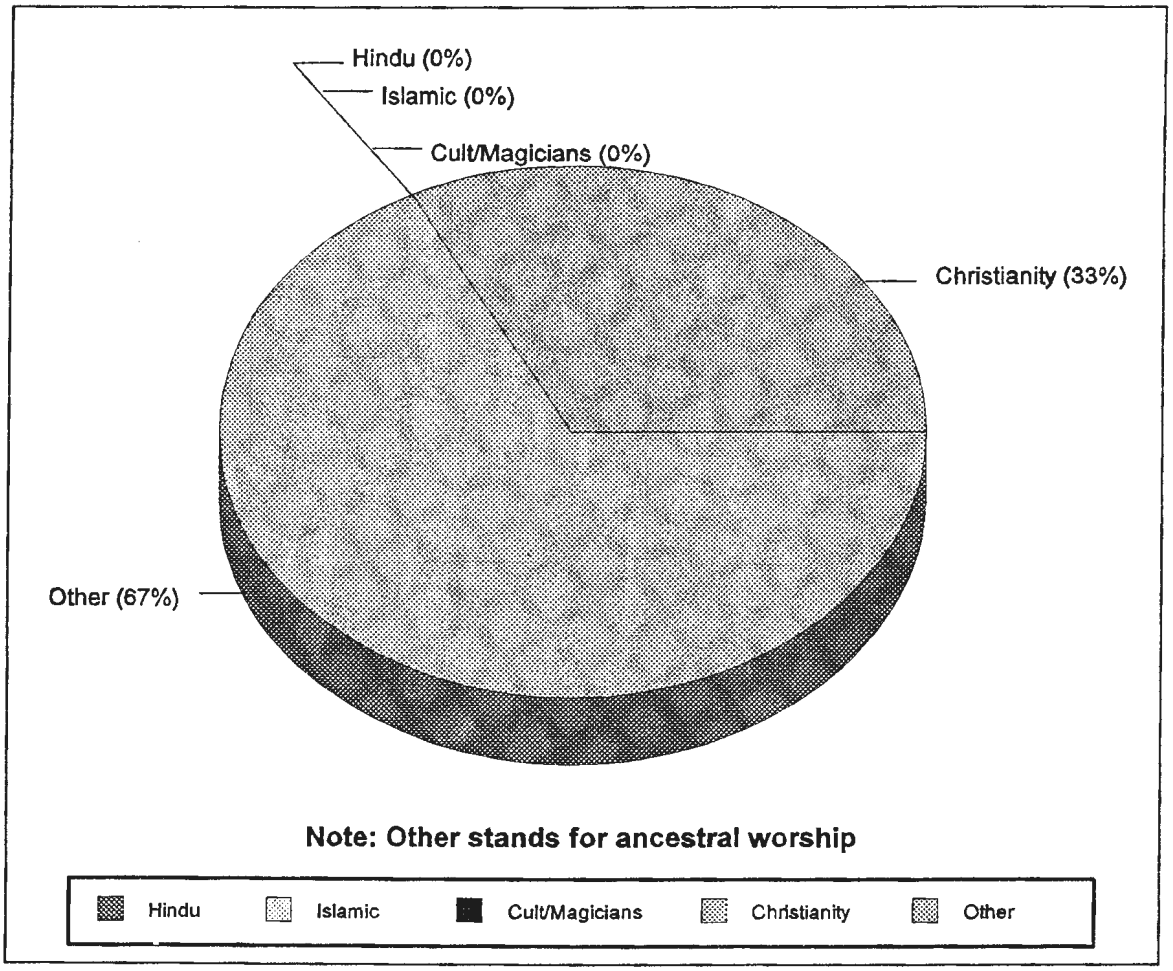
Educational status seems to be of no importance in becoming a traditional healer, for example 59% of the healers were not educated, and 7% dropped out of school at the level of Std 10-5. Seven percent had up to a Diploma level and 27% ranged between Std 6-10. The majority of traditional healers did not receive formal education to be eligible for traditional healing. The

sample left us with no traditional healer who holds a degree.

Item 6: Religion

Figure 5.5.

Religious affiliation of traditional healers



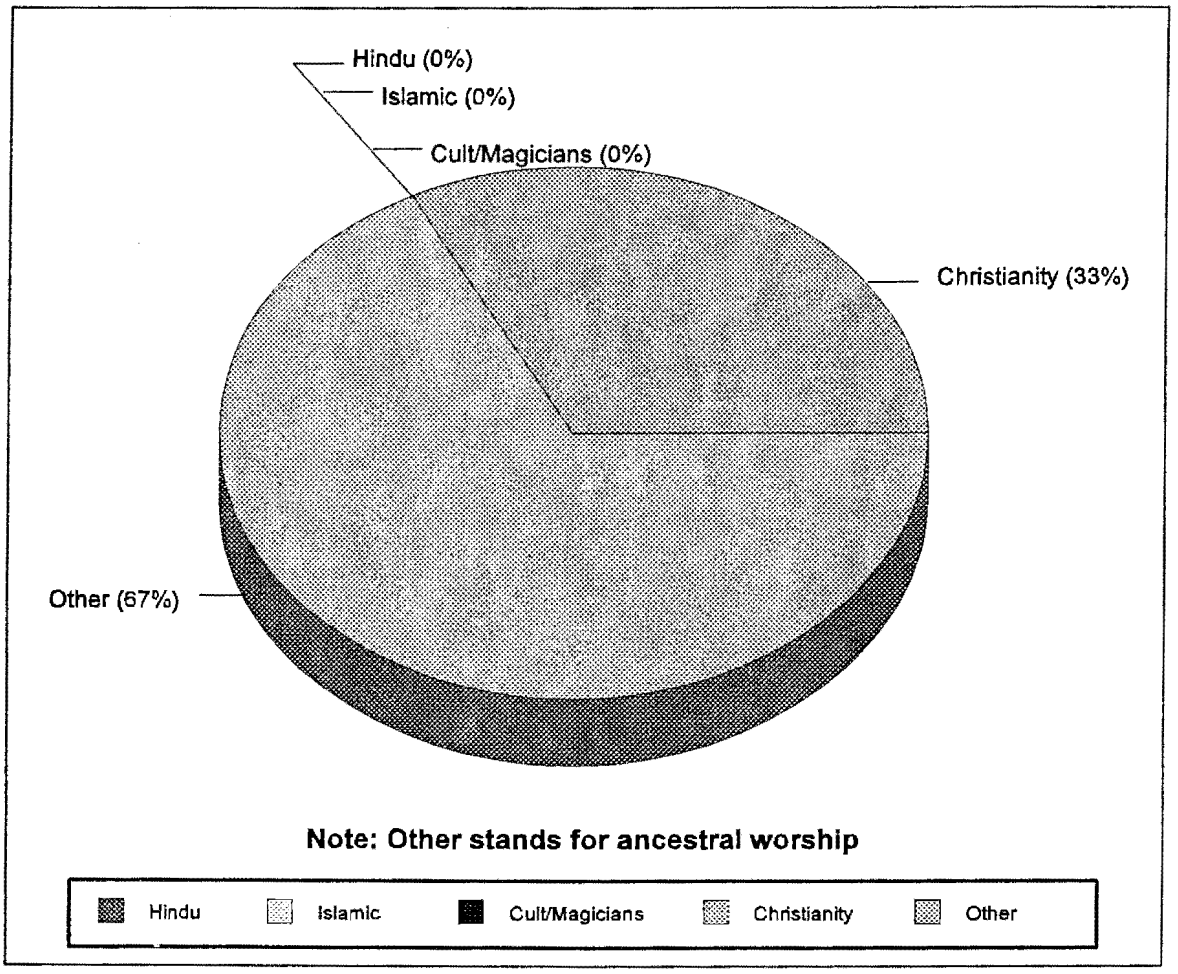
More than half (67%) of the traditional healers did state that they worshiped their ancestral spirits whereas 33% were Christians. From these figures, one may conclude that traditional healing has got something to do with the superstitious belief or ancestral worship than with God.

sample left us with no traditional healer who holds a degree.

Item 6: Religion

Figure 5.5.

Religious affiliation of traditional healers

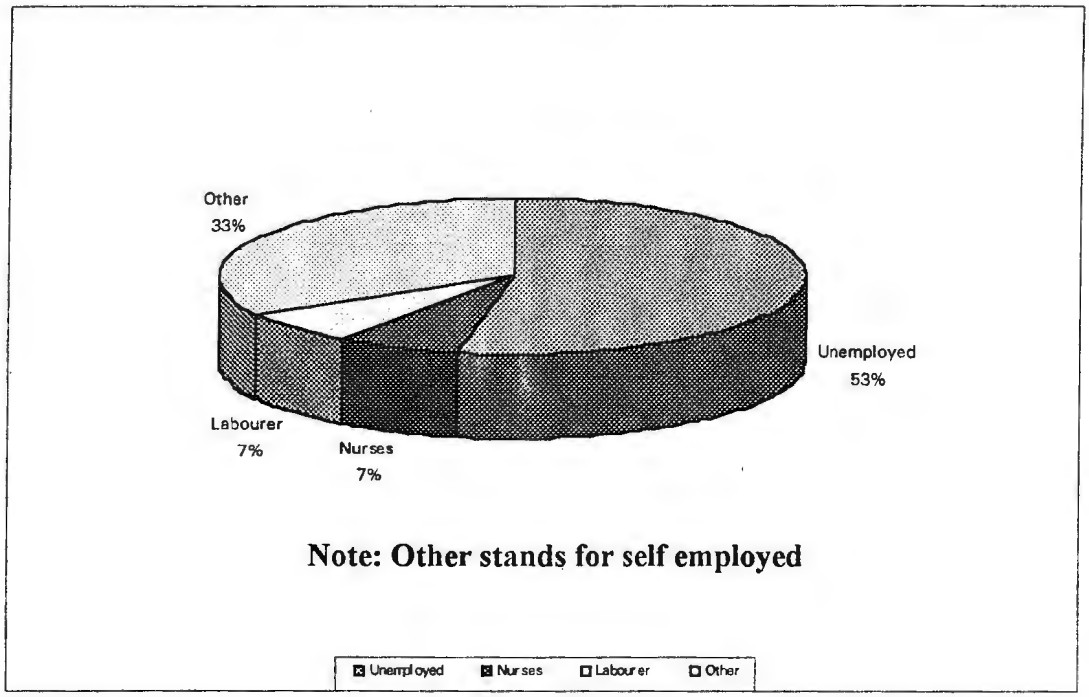


More than half (67%) of the traditional healers did state that they worshiped their ancestral spirits whereas 33% were Christians. From these figures, one may conclude that traditional healing has got something to do with the superstitious belief or ancestral worship than with God.

Item 7: Occupation

Figure 5.6.

Occupations of traditional healers



Amongst traditional healers 53% were unemployed, meaning that they needed to be in the house for availability reasons. Only 7% nurses and the other 7% constituted of labourers while 33% constituted of those with other occupations for example: self employed, part time workers and etc. Some of the traditional healers were full-time and some part time in traditional healing practices.

5.2.2 Qualitative Data Analysis

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. Although the overall aims of both

qualitative and quantitative analysis is to organize, synthesize and provide structure to research data, with the difference that data collection and data analysis usually occur at the same time in qualitative studies (Polit and Hungler 1993; Miles & Huberman 1994). The researcher designed a mechanism for gaining access in the parts of the data collected by developing a method for indexing the content called the coding scheme.

5.2.2.1 The coding scheme of major topics

The coding scheme was developed using the research questions as a frame of reference. The categories arrived at are awareness, collaboration, acceptance and legalization.

❖ **Awareness**

Item 1: Do you think the community (people) knows that you exist?
The perception of all (100%) traditional healers who participated in the research was that the community know that they exist.

Item 2: Do people come seeking your help?
All (100%) traditional healers agreed that people come seeking their help.

❖ **General comments**

Item 15: Give your comments regarding the importance of your practice
When asked to give comments regarding the importance of their practice, the following were narrated by traditional healers, that they

- are healing people,
- can protect people from witches,

- protect the new born babies,
- save most lives,
- are called by their ancestral spirit without discrimination, that is whether educated or not,
- charge fees that are cheaper than hospital fees,
- can separate dangerous plants from good ones,
- can determine the cause of disease and death, and
- help patients who come after doctors have failed to cure them.

❖ **Collaboration**

Item 5: Do you think it is necessary for your services to be regarded as part of the total health care system?

All (100%) traditional healers felt the need to be regarded as part of the total health care system.

Item 6: Can you work hand in hand with nurses, doctors and other health care professionals?

All (100%) traditional healers agreed that they could work hand in hand with other health care team members.

Item 14: How best can you work as a team with other health professional?

In response to this question traditional healers had the following to say:

- They could refer patients to hospitals if that could be acceptable, when they are unable to cure the disease.
- They also would like to visit their patients while hospitalized and
- They would like a two-way type of referral system put in place healers hospital, and that
- They would like to share ideas about patient prognosis.

Table 5.1.

Team work (N=15)

CATEGORY	FREQUENCY	PERCENTAGE
Refer patients to the hospital	2	13.4
Like working as village health workers	10	66.6
Like a two-way type of referral, that is, from traditional to modern and vice versa	2	13.4
Share ideas about patient prognosis	1	6.6
Total	15	100%

❖ **Acceptance**

Item 7: Do other health care practitioners accept your practice?

More than half (73.4%) of the total sample stated that they were well accepted by the community and other health team members because: -

- Some health workers consulted traditional healers – especially those with infertility problems and STD's.
- Some health workers advised patients to go and try traditional healers.
- At a certain stage they were allowed to pray for their patients.

Less than a quarter (13.3%) reported that they were not accepted because:

- People associated them with witchcraft.
- People took them as liars.
- Some people hated the bones they used as being unable to tell the truth.

Less than a quarter (13.3%) were not sure whether they were accepted because:

- They found it difficult to know whether people visiting them were

health workers or not.

- One was a student who was still practicing under the supervision of the master.

❖ **Legalization**

Item 3: Is it important to be registered?

The majority (80%) of the informants needed to be registered for several reasons such as,

- To be known to other people.
- To be able to hold meetings with nurses and doctors.
- For the government to give them money to develop themselves.
- For the law to protect them from being killed by youths through misidentification as witches.

Less than a quarter (20%) of the total sample did not want to be registered for the following reasons:

- The ancestors would fight them if they associate themselves with others.
- They are not practicing for gain.
- They are unable to read and write.

Item 4: Do you think you must be regarded as health professional?

All (100%) traditional healers agreed that they should be regarded as health care professionals because they were also rendering their health care services to their clients/patients.

❖ **Training of traditional healers**

Item 8: Do you think your practice needs training in an institution for certification?

More than half (80%) of the traditional healers stated that their practice could be taught in an institution which gives a certificate at the end because of the following reasons:

- It is a call, not a wish
- It is the supernatural spirit that chooses the area for training and usually it is the inyanga's house or home.
- At times it can descend from parents to children through training.
- One needs to be called first by a god to be a faith healer.

Less than (20%) of these traditional healers who appeared to be herbalists agreed to the fact that they trained and were given certificates, because:

- They felt they learnt a lot and such knowledge should be written down.
- Some had undergone training and were given certificates.

Item 12: How do you acquire this knowledge and skills to be able to help people with illness? State:

- Through training by either a sangoma, inyanga, diviner and by a call from God.
- The table below illustrates the duration of traditional health training.

Table 5.2.

Duration of training (N=15)

PERIOD OF TRAINING	FREQUENCY	PERCENTAGE
One year	2	13.3
One year two months	1	6.7
One yea six months	2	13.3
Two years	3	20
Three years	1	6.7
Four years	1	6.7
Six years	1	6.7
Indefinite	2	13.3
Not applicable	2	13.3
Total	**15**	**100%**

Looking at the duration of training traditional healers, the sample revealed the fact that the period of training was not stable or equal but depended on the individual's traditional trainer. This may be so because no formal set of rules are followed as there is no formal legalized training which prescribes the course and its duration of training.

❖ **Diseases that can be transferred or treated by traditional healers**

Item 9: Can you list diseases that can be best treated by you or any of the traditional healers?

The table below shows the different diseases that can be treated by traditional healers.

Table 5.3.

List of diseases handled by traditional healers (N=15)

CATEGORY	FREQUENCY		PERCENTAGE
All	*	2	13.3
STD and "drop"	*	10	66.7
Infertility	*	7	46.7
Impotency	*	6	40
Mental disorders	*	7	46.7
Wounds and sores	*	3	20
Diabetes	*	2	13.3
Hypertension	*	2	13.3
Cleaning Blood		1	6.7
Child diseases	*	3	20
TB		1	6.7
Asthma		1	6.7
Peptic ulcers	*	2	13.3
Epilepsy	*	3	20
Heartburn		1	6.7
Prolapsed uterus	*	2	13.3
Gastro intestinal disturbances	*	3	20
Body pains		1	6.7
Kidney and urinary problems	*	3	20
Swollen testicles		1	6.7
Backache		1	6.7

Note: One participant had been given a chance to can list diseases that he/she can handle which resulted in intersection frequency of diseases. * represents more than one intersection.

The most important diseases based on the frequency of responses are, STD and "drop", infertility, mental disorders as well as impotency which seems to be getting a greater attention by the traditional healing system.

Item 10: Which diseases can you refer straight to the hospital?

The table below reflects diseases that can be referred to the hospital by traditional healers.

Table 5.4.

List of diseases that are referred to hospital by traditional healers (N=15)

CATEGORY	FREQUENCY		PERCENTAGE
Gastro-intestinal disorders	*	6	40
Fractures and broken bones	*	15	100
Shortage of blood	*	3	20
Burns	*	4	26.7
Women in labour	*	4	26.7
Bleeding	*	2	13.3
Cuts/injuries	*	7	46.7
Mental illness	*	2	13.3
Diabetes		1	6.7
Very ill patients	*	2	13.3
Unconscious patient		1	6.7
TB	*	3	20
Circumcision		1	6.7
Heart problems		1	6.7
Malaria		1	6.7
AIDS		1	6.7

Note: One participant had been given a chance to can list diseases that he/she can refer either the clinic or hospital, which resulted in intersection frequency of diseases referred * represents more than one intersection.

Diseases referred to hospital were fractures and broken bones, gastro-intestinal disorders and cuts/injuries.

Item 11: Can you openly show other professionals how you operate?

All (100%) traditional healers were not in favour of showing other health professionals how they operate.

5.3 HEALTH PROFESSIONALS

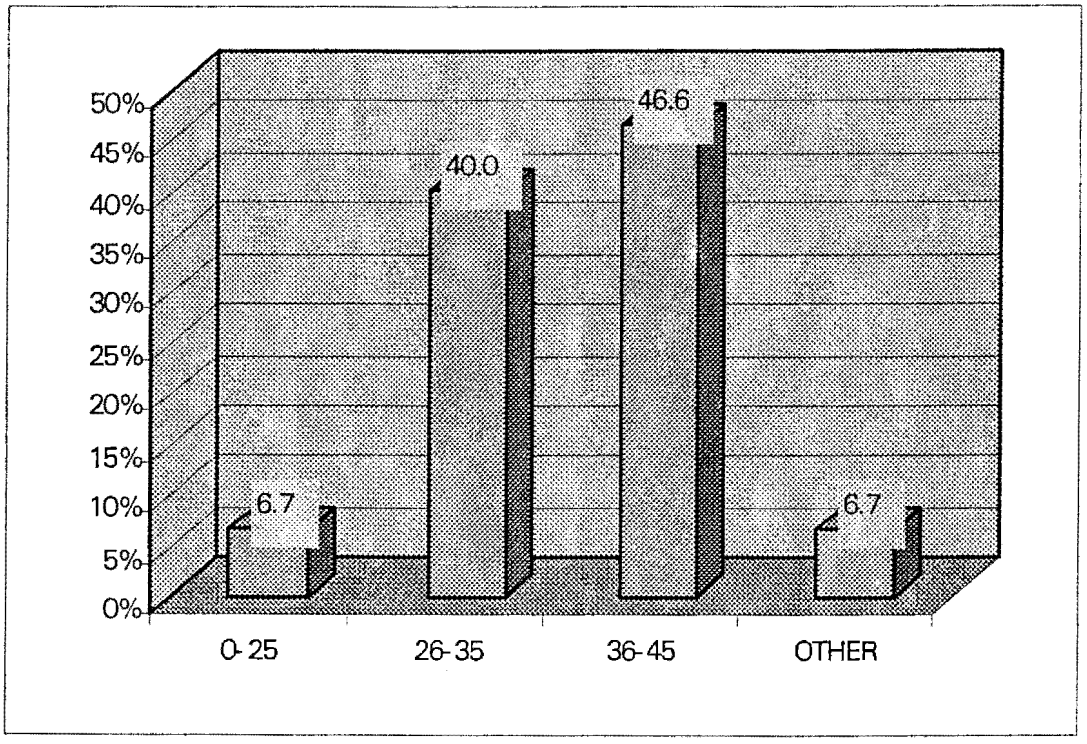
5.3.1 Quantitative Analysis

❖ **Demographic Information**

Item 1: Age

Figure 5.7.

Age distribution of health professionals (N=15)



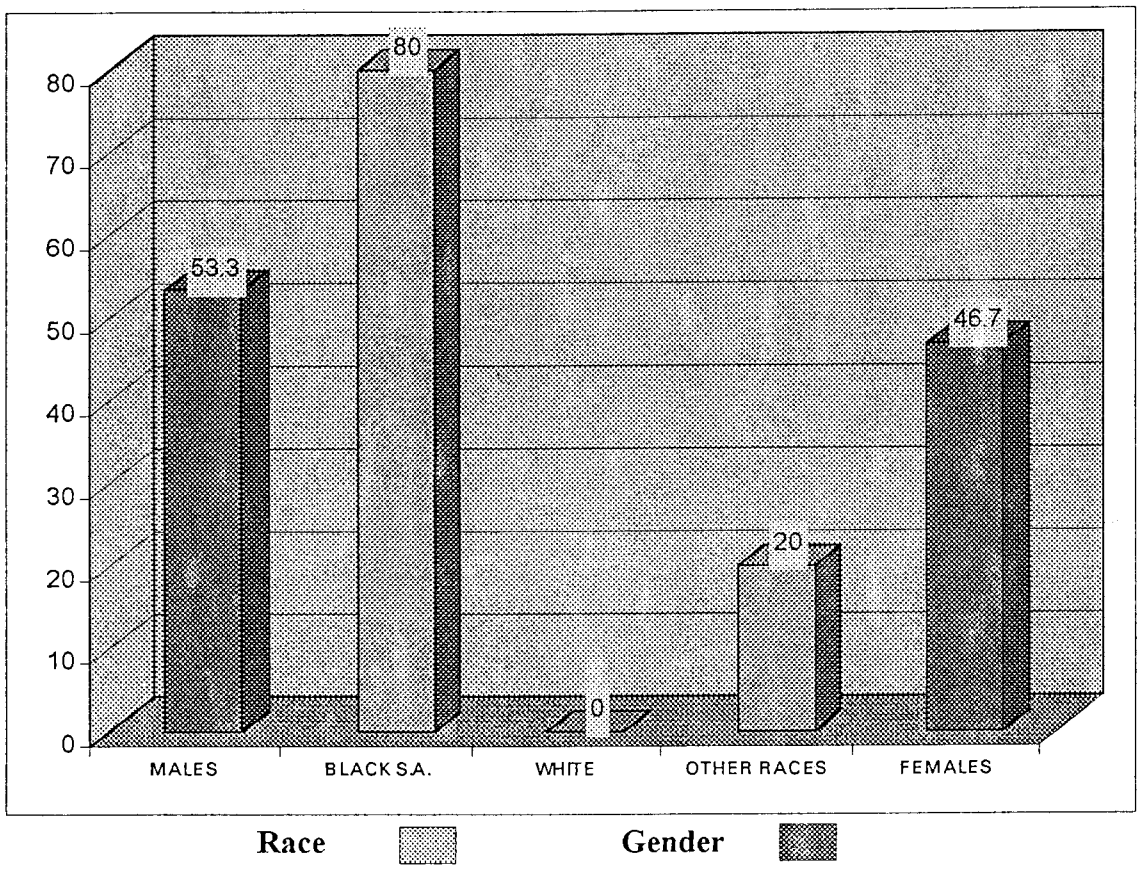
For all health professionals who were interviewed, 6.7% were those between the age of 0 and 25, 40% were between 26-35, 46.6% were between 36-45 and only 6.7% were above 45 years of age. This illustration exposes the idea that traditional healers of this sample do work even when they are very old. The majority of the professionals in the sample ranged between 25-45 years and from there most of them were no longer available in the modern health

care practice. They were usually allocated in the following departments as managers: others in universities and colleges as lectures and principals and some retired due to ill-health or disability. This left more opportunities to traditional healers to be in close contact with the patients.

Item 2 to 3: Gender and race

Figure 5.8:

Gender and race of health professionals (N=15).



Eighty percent (80%) of the health professionals were black South Africans and 20% other racial groups and no one was white. This indicates that the majority of our health professionals are black South Africans even though it is a Rainbow society. Of the 15 participants 53.3% were males and 46.7% were females. It is now clear that males are also entering into the profession and are willing to be part of the

changes affecting their profession.

Item 4: Marital status

Table 5.5.

Marital status of health professionals

CATEGORY	FREQUENCY	PERCENTAGE
Married	12	80
Single	3	20
Widowed	0	0
Divorced	0	0
Other (Never Married)	0	0
Total	**15**	**100%**

Table 5.5 illustrates the fact that the majority (80%) of health professionals who took part in the study were married whereas 20% were single. The total outcome of the sample regarding marital status may be concluded as saying that the health professionals are mature enough to be responsible and accountable for the well-being of their patients.

Item 5: Educational level

Table 5.6.

Educational levels of health professionals

CATEGORY	FREQUENCY	PERCENTAGE
Not educated	0	0
STD 0-5	0	0
STD 10 and above	1	6.6
Diploma	7	46.7
Degree	7	46.7
Total	**15**	**100%**

Table 5.6 reflects the fact that health professionals who participated in the study were above the level of Std 10 with 46.7% for both diploma and degree training. This shows that element of illiteracy in responding was not a bias because more than 90% had tertiary education.

Item 6: Religion

Table 5.7.

Religion of health professionals

CATEGORY	FREQUENCY	PERCENTAGE
Christianity	15	100
Hindu	0	0
Islamic	0	0
Cult or Magician	0	0
Other	0	0
Total	**15**	**100%**

All health professionals who participated in the study fell under the Christian religion. This indicates that even if they do not worship ancestors, their being Christians did not bias them in seeing the need of traditional healing amongst patients under their care.

Item 7: Occupation

Table 5.8.

Occupation of health professionals

CATEGORY	FREQUENCY	PERCENTAGE
Unemployed	0	0
Doctor	2	13.3
Nurse	9	60
Paramedic	3	20
Labourer	0	0
Other	1	6.7
Total	15	100%

Table 5.8 indicates that all health professionals were employed during the time of the study. Thirteen percent (13.3%) were doctors, 60% were nurses, 20% were paramedics and 6.7% represented medical technology. The nurses were a higher percentage which was appropriate because they are the ones who spend more time with patients.

5.3.2 The Coding Schemes of Major Topics

The coding scheme was developed using the research questions as a frame of reference. The categories arrived at are awareness, collaboration, acceptance and legalization.

❖ **Awareness**

Item 10: Do you know of any person who was completely cured by a traditional healer? If yes defend it and state whether the practice is fading away or not?

Though 73.3% of the sample health professionals showed no knowledge of anybody who got completely cured by traditional healers only 26,7% of the health professionals did confirm a total cure of patients who visited traditional healers.

Item 11: Is the practice fading away?

Sixty percent (60%) of the total sample of health professionals confirmed the idea that the practice was not fading away, whereas 40% proclaimed that traditional healing practice was fading away.

❖ **Collaboration**

Item 3: Because you are one of the multi-disciplinary teams can you accept traditional healers in this team?

The total sample of health professionals revealed 66.7% of those that disagreed with the idea of collaboration, whereas 33.3% agreed to the idea.

❖ **Acceptance**

Item 1: Do you think traditional health system is to be regarded as an important health care facility in any society?

Of the total health professional sample, 66.7% regarded traditional health care as an important health facility in any given society against 33.3% who disagreed with this idea.

Item 2: Do you believe that other diseases need traditional healers?

Of the total sample of health professionals 66.7% believed that there were diseases that needed traditional healers whereas 33.3% disagreed with the idea as illustrated in the table below.

Table 5.9.

List of diseases that need traditional healing (N=15)

CATEGORY	FREQUENCY		PERCENTAGE
Mental illness	*	4	26.6
Infertility	*	3	20
Childhood diseases		1	6.6
Potency	*	2	13.3
Demon possession	*	2	13.3
Sprains/fractures		1	6.6
Chronic skin disorder		1	6.6
STDs	*	7	46.6
Psychosomatic disorders		1	6.6
Nutritional disorders		1	6.6
Cancer		1	6.6
Measles		1	6.6
Flu		1	6.6

Note: One participant had been given a chance to can list diseases that he/she can handle which resulted in intersection frequency of diseases. * represents more than one intersection.

The above table shows diseases that need traditional healing. STD's, mental illness and infertility are scoring higher percentages. In conclusion these are diseases that seem to be given more attention by traditional healers.

Item 8: Can a traditional healer visit his/her patient in your place of practice?

While hospitalized, a patient can be visited by anybody accepted by himself. This makes it necessary for health professionals to re-consider this idea. Amongst health professionals who participated in the study, 40% agreed to the fact that patients could be visited by traditional healers, an equal number (40%) disagreed and one 20% were not certain whether they could accept visitations or not.

Those who agreed are in line with the Patients Right Charter (1999) which states:

> .... it is necessary for Modern Health Care System to collaborate with traditional healers. This collaboration will make it easier for health professionals to release the patient for traditional health care if needs be.

Item 9: Is there anything you are not in favour of with regard to traditional healing?

Health professionals were not in favour of traditional healers because of the following:

- Most of them claim that they can cure all diseases.
- Their areas of operation are too dirty (poor hygienic conditions).
- They use over dosages of their medicines without considering age.
- They lack proper standards of training.
- Most of them are money-orientated.

- Some still use one blade for cutting all their patients and this can spread HIV/aids.
- They do not diagnose properly.
- Sterilizing is not known to them.
- Their approach is not scientifically proven.
- Their medications have no expiry dates.

❖ Legalization

Item 6: Do you want traditional healers to be legalized?

Of the total health care professional sample, 66.7% wanted traditional healers to be legalized whereas 20% of them were not sure whether they could be legalized. Only 13.3% totally rejected the idea of traditional legalization. This profile clearly indicates the need for legalization of traditional healers.

❖ Diseases that can best be treated by traditional healers

Item 4: If your answer to number 2 is yes, can you list diseases that you feel need traditional healing?

(See Table 5.9)

Item 5: While in the hospital situation, did you ever come across a situation where a patient needed traditional healers or relatives demanding discharge of their family member for traditional health care?

It is clearly indicated by the percentage that patients do demand traditional healers when they think that modern medicine is failing them. Ninety three-coma three percent represents health professionals who in a hospital situation came across a situation where a patient needed a traditional healer or a relative demanding discharge of the patient to be able to send them for traditional healing. Only 6.7% of the participants had never

experienced this situation.

❖ Referral process

Item 7: Can you support referral of patients to and from traditional healers?

Despite the fact that traditional healing is made up of three types, herbalists, faith healers and diviners, health professionals see the need to transfer patients to and from traditional healers which in other words means that they need collaboration. About 46.6% are not in favour of the idea of referral of patients to and from traditional healers. The researcher therefore concludes that collaboration will be the key to health for all South Africans in the year 2000 and beyond.

❖ General comments

Item 12: Give your general comment regarding traditional healing practice and its inclusion into the main stream of health care ministry.

The following were comments given by the health professionals:

- Health professionals cannot deny patients from their rights of choosing any health system, hence traditional health system inclusion.
- The practice must be standardized, regulated and have proper codes of practice because most people believe in it.
- They are most accessible to most rural communities.
- They should also have a code of conduct and discipline.
- They should improve with regard to hygienic conditions.
- Their inclusion should be such that all harmful practices on human lives are controlled.

5.4 CONSUMERS

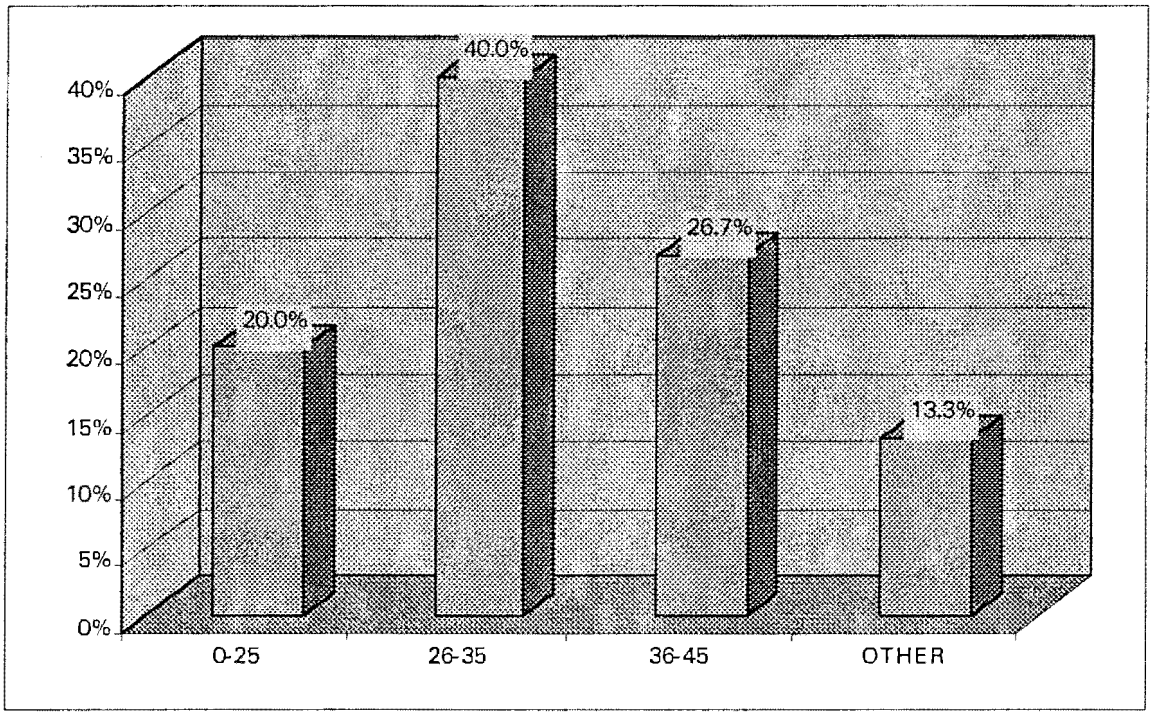
5.4.1 Quantitative Analysis.

❖ **Demographic information**

Item 1: Age

Figure 5.9.

Age distribution of health care consumers



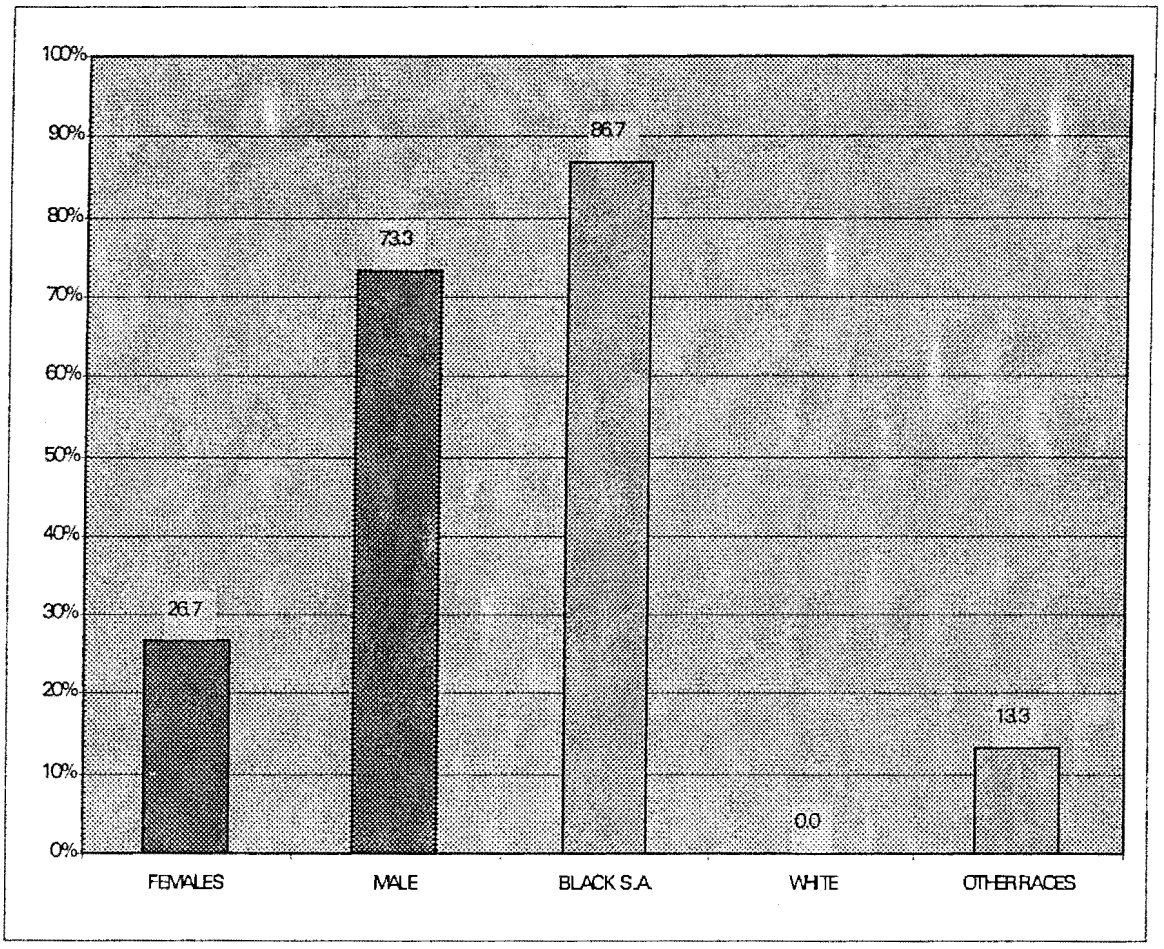
Note: Other stands for ages above 45

Twenty percent (20%) of the consumers who participated in the research study were those whose ages ranged between 0-25 years, 40% were between 26-35 years old, 26.7% were between 36-45 yeas and only 13.3% fell under other category. Looking at the age distribution, the sample population age is on the average composed of those who utilize traditional healing system, between 0-70 plus.

Item 2 to 3: Gender and race

Figure 5.10

Gender and race of health care consumers



Note: Others stands for immigrants

Gender

Looking at Figure 5.10, the genders of health consumers' sample depict the fact that males are utilizing traditional healers more than female. This is indicated by differences in their percentages, which are 73.3% for males and 26.7% for females.

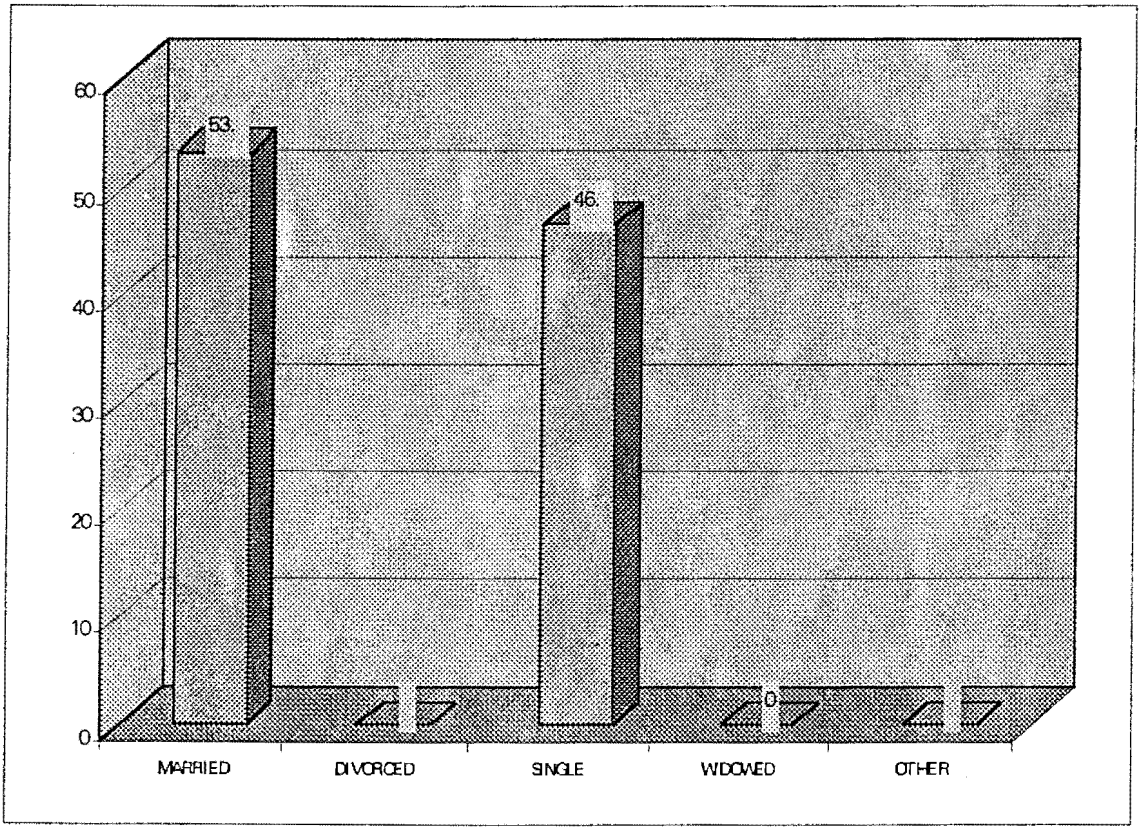
Race

More than half (86,7%) of the total sample of health care consumers were blacks and only 13.3% were other racial groups, leaving us with nobody who was a white consumer. This implies that blacks are the most people who are utilizing traditional healing system. That is why it needs to be recognized in most black communities.

Item 4: Marital status

Figure 5.11.

Marital status of health care consumers



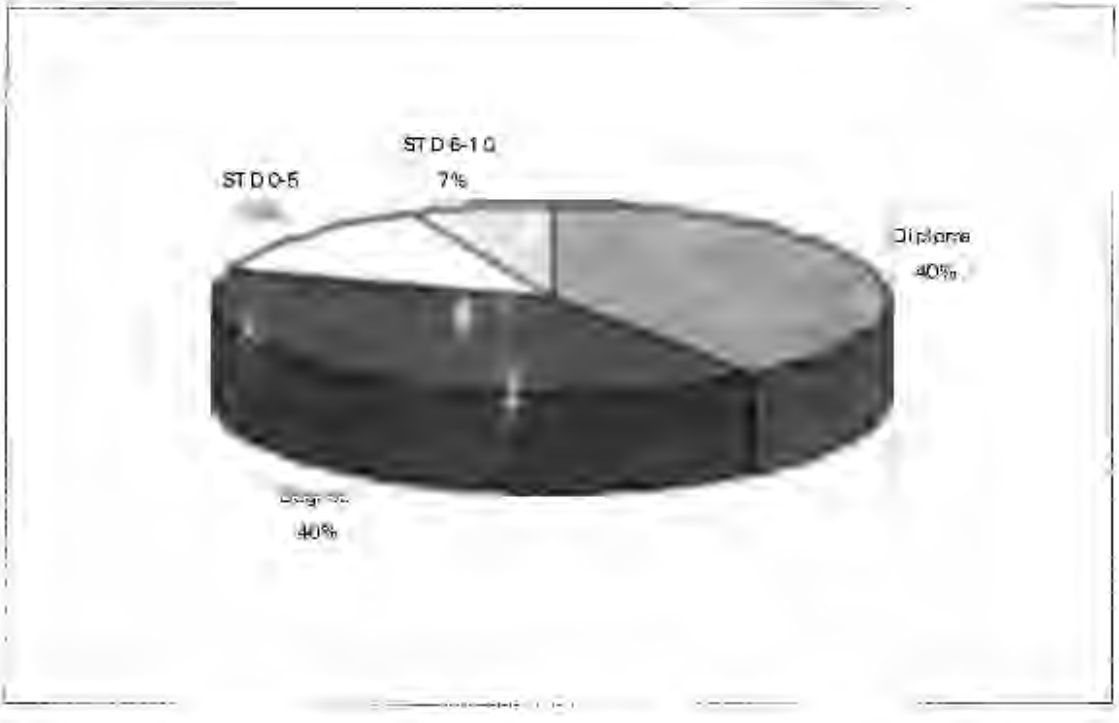
From the diagram above 53.3% of the total number of participants were married people, 46.7% were single, 0% widowed 0% divorced and 0% others. Married

people and single people were the major elements of the sample, as compared to widowed and divorced. It will then mean that traditional health care system is utilized most in many communities. This shows that the system will remain in force forever.

Item 5: Educational status

Figure 5.12.

Educational status of health care consumers



The diagram indicates percentages of educational levels of the health care consumers who participated in the study. Forty percent (40%) had a diploma, the other 40% had a degree, 6.6% were whose educational status ranged between Std. 6 - 10 and 13.4% ranged between Std. 0-5. Eighty percent (80%) of the consumers had a higher level of education, which gives one the reason that they saw the need for traditional health care system. It also became clear that the need for utilization of traditional healing could never be biased because of one's educational status.

5.4.2 The Coding Scheme of Major Topics

The coding scheme was developed using the research questions as a frame of reference. The categories arrived at were awareness, collaboration, acceptance and legalization.

❖ **Awareness**

Item 1: Have you ever visited a traditional healer?

The table below illustrates the way in which the health care consumer sample utilized the traditional healing system

Table 5.10.

Utilization of traditional healing

CATEGORY		FREQUENCY	PERCENTAGE
"Visited" traditional healers	Yes	5	33.3
	No	10	66.6
"Used" traditional medicines	Yes	7	46.6
	No	8	53.3
"Need" traditional healers	Yes	1	6.6
	Uncertain	5	33.3
	No	9	60
"Prefer" traditional healers to medical doctors	Yes	0	0
	Uncertain	4	26.6
	No	11	73.3

The general outcome of the health care consumers who participated in the study was that the highest percentage of participants (66.6%), was said to have had not visited traditional healers.

Item 10: Comment/explain your personal view with regard to traditional healing.

On being asked to comment or give their personal views regarding traditional healing health care consumers stated that:

- Traditional healers were playing a very big role in the community and if legalized could work hand in hand with modern health practitioners to improve the health of many people in the society.
- Patients had a right to choose who to consult be it a doctor or a traditional healer and if traditional healing were to be accepted then they would feel free to refer their patients to the traditional healers.
- Some traditional healers were usually not sure of their medications and turned to overdose patients and were also expensive.
- They should only concentrate on ailments that they could cure and refer others to modern medicine and again they should only use genuine herbs.
- Traditional medicine was good because it was in operation for years even though some people associated it with witchcraft.
- Traditional healers should allow their medicines to be subjected to scientific scrutiny and also should be encouraged to remove the spiritual elements from their prescriptions and cures.
- Doctors should be well informed about traditional healers and stop being mean to traditional approaches. In fact, traditional healers should have the same status as medical doctors.
- Traditional healers must have ways of testing their patients for allergies.

❖ **Collaboration**

Item 6: While hospitalized did you ever feel a need to try traditional healers?

The total sample of health care consumers (100%) denied the idea of having felt any need for traditional healers while hospitalized.

Item 7: Will you be happy if traditional healers can be members of the health team both in hospital and in the community?

Just a third (33.3%) of the consumers agreed that traditional healers were included in the health team both in hospital and in the community. Again 46.7% were skeptical about the idea that they remained uncertain, living 20% totally disagreeing with the idea of inclusion of traditional healers into the health team.

Item 9: Do you support the idea of allowing traditional healers' visit patients in hospitals?

More than a quarter (26.7%) of the health care consumers did not agree that traditional healers be allowed to visit their patients in hospitals, and 26.7% were uncertain. Nearly half (46.6%) did not support the idea that traditional healers visit hospitalized patients.

❖ **Acceptance**

Item 2: Have you ever-used traditional medication for any sickness?

(See Table 5.10 above)

Item 3: Do you think you will ever need a traditional healer in your life?

Table 5.10. shows that 6.6% needed traditional healers and 33.3% were uncertain whereas 60% shows no need of using traditional healers.

Item 4: Do you prefer traditional healers over medical doctors?

Table 5.10 shows that 26.6% were uncertain regarding their preference of traditional healers to medical doctors whereas 73.3% showed the denial of traditional healers over medical doctors.

❖ **Legalization**

Item 8: Do you want traditional healing to be legalized?

More than half (60%) of the health care consumers needed traditional healers to be legalized and 26.7% were totally in disagreement with the idea, leaving 13.3% not sure whether traditional healing be legalized or not.

❖ **Diseases that can best be treated by traditional healers**

Item 5: List diseases that you feel can best be treated by traditional healers

The table below illustrates diseases that the consumers felt could best be treated by traditional healers.

Table 5.11.

List of diseases that the consumers feel can be best treated by traditional healers

CATEGORY	FREQUENCY		PERCENTAGE
None	*	6	40
"Tshipfula" Ulcer	*	2	13.3
"Drop" (STD)	*	8	53.3
Epilepsy	*	2	13.3
Scabies		1	6.6
Diphtheria		1	6.6
Malaria		1	6.6
Infertility	*	2	13.3
GIT tract	*	2	13.3
Mental illness	*	2	13.3
Skin diseases/wounds		1	6.6

Note: One participant was given a chance to list diseases that he/she could handle which resulted in an intersection frequency of diseases. * represents more than one intersection.

Although 40% of the frequency have denied that traditional healers could heal the disease in the table above, 53.3% of the total illustrations of diseases was "Tshipfula" which is a form of an ulcer that takes long time to heal has been rated high by the health care consumers.

5.5 LIMITATIONS OF THE STUDY

5.5.1 Research Setting

The area identified appeared to be slightly bigger as compared to the sample size. This was so due to the fact that the regions are demarcated following political boundaries, which appear to be far apart.

5.5.2 Sample Size

Three samples were identified with fifteen (15) health professionals, fifteen (15) traditional healers and fifteen (15) health care consumers. The size was affected by the idea that traditional healers could not be easily identified or located, as they were not all formally registered. Health professionals and health care consumers were readily available. The only problem was that health professionals were finding it difficult to complete questionnaires in the presence of the researcher because they wanted to avoid the idea of being associated with the information they gave.

5.5.3 Translation

Questionnaires were prepared in English and this demanded the researcher to translate them into "Tshivenda" to most of the traditional healers and health consumers who could not understand English.

5.5.4 Pilot Study

The pilot study that the researcher conducted to validate the study had an effect on the number of traditional healers. This is because the five who were consulted could not form part of the main study. It became very difficult for

the researcher to identify the other 15 traditional healers as most of them seemed very isolated.

5.5.5 Practical Problems

Most traditional healers did not want to disclose their information to a stranger, and this demanded persuasion from the side of the researcher. Most health professionals took more than 5 days to answer their questionnaires, regardless of the fact that they were short. The researcher was left with no option, but to do several follow-ups. Health care consumers had no problems.

5.6 SUMMARY

From the data gathered and the analysis made, it has become clear that modern health care workers should collaborate fully with traditional healers if health care services are meant to be beneficial to the community. It is now necessary for medical practitioners (nurses, doctors and paramedics) to be given the opportunity of studying anthropology in their curriculum so that they can have knowledge regarding cultural differences and similarities. Unless this collaboration is done a healthy nation of South African nation will never come into being.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter will provide a synopsis of the multidisciplinarity in health care delivery system, focusing specifically on the role played by the traditional healer. Subsequently, concluding remarks based on the research findings will be presented. Finally, recommendations that are practical will be made.

6.2 THE PURPOSE OF THE STUDY

The World Health Organization in the ninth Declaration of Alma-Ata gave a declaration in conjunction with other health ministries of formulating a policy that allows utilization of all available resources, including traditional healing resources.

It is in this light that "Traditional Healing as a Healing System in a Multi-Cultural Society" was examined. The qualitative and quantitative approaches were blended in this investigation. The tools for data collection were developed and pretested in the same area, using different participants with similar demographic characteristics.

The data was gathered over a period of 18 months. The participants were 45 in total. Their demographic characteristics included age, marital status, educational level, gender, occupation and religious affiliation, among others. They were all African people; this was inevitable, given the topic that is being addressed. The methodology was exploratory and quantitative. The analysis, however, entailed the integration of both qualitative and quantitative designs. The pilot project was used for validation purposes and to concurrently pretest the tool, which preceded the

main study.

6.3 DISCUSSIONS OF THE FINDINGS

6.3.1 Perceptions that Health Professionals Seem to Have About Traditional Healers.

Though it is clear that the majority of health professionals have little to do with traditional healers, they do consider that traditional practices could never be ignored. Health professionals are fully aware of the fact that traditional healing is rated high in most of the individuals' value systems.

The following are the perceptions of health professionals about traditional healers:

- They think that traditional practices are rather "primitive", as they are not scientifically grounded.
- Their works are not subjected to research and scrutiny by the human resource council in order to exclude things like: uncalled for deaths from herbal poisoning following wrong measurements and strength.- damage of vital organs like kidneys, brain as well as the liver.- unnecessary provocative information about causes of disease and people responsible.
- Some of the traditional healers do lie about the causes of the illness and this results in a lot of disharmony amongst family members and their neighbours.
- Other health professionals do recommend traditional practices, if they could only focus on diseases they can cure not on profit.
- Another drawback about their practice is that they claim to be able to cure all types of diseases and sicknesses.
- In cases where they think that payments could be difficult, they frighten their clients by telling them that if they do not pay, they would

run mad and walk naked.

- Some use strong purgatives even on very ill patients who may end up collapsing following diarrhea.
- They also use emetics in order to remove evil spirits.
- Their medications do not have specific strength or measurements for people of specific ages, for example, infants, children and adults.

6.3.2 Perceptions of Traditional Healers Regarding Health Professionals

- Health professionals are very proud as if they are not part and parcel of the traditional society.
- They pretend not to have anything to do with traditional health practices, but the practices were used by their parents as a means of raising them up.

Regarding the collaboration of traditional healers with modern health professional traditional healers depicted the following:

- White doctors may kill them
- They may be arrested that they were practicing without licenses
- They may be asked to stop practicing or threatened
- Their ancestral spirits might refuse them to share the knowledge with others
- It might be difficult to practice in a modern type of a house because they are demanded to practice from a special type of house (traditional rondavel), and it must be separated from the rest of the houses in their home steads.

6.3.3 Perceptions of Health Care Consumers Regarding Both Traditional Healers and Health Professionals.

The researcher deduced that most health care consumers were more than ready to use one or both health systems. They could clearly indicate the following perceptions about traditional healers, that:

- Traditional healers must try and improve their personal and environmental hygiene, including their eating utensils like drinking mugs, bottles as well as other containers used for storing medication.
- They should exclude the idea of pointing at people claiming that they are the cause of illnesses, but should concentrate on disease management.
- They must avoid the use of one razor blade as this can cause diseases like HIV/AIDS to be transferred from one person to the other.
- They should openly say if they cannot help the patient \ client, rather than delay the patient giving him or her false hopes.
- They need monitoring by the government, as most of them are practicing with no skills.
- Their prices need to be regularized somehow, in order to avoid exploitation of health care consumers by traditional health providers.
- They are highly accepted by the community because they are ready to help people regardless of the time of the day e.g., in the night.
- They can treat patients even if they are have no though they ask them to pay later.
- They relate well with the natural etiology of the disease, that is its root culturally-linked cause.
- They are readily available and acceptable, because they are part of the society, and stay with their clients, and practice within the normal acceptable norms and values of the society.
- In most instances the client does not need an interpreter, as in most

cases the language would be known by the client or a family member.

Most health care professionals regard visiting traditional healers as "primitive" and uncivilized. Due to this perception consumers usually hold back information of consulting traditional healers, which makes it very difficult for the doctors to trace easily the cause of the problem including complications. They deny patients to try traditional healing methods in cases were medical cure is uncertain, like in the case of cancer, HIV/AIDS and diabetes mellitus and many others.

If they can discover that a patient used traditional medicines, it becomes very difficult for them to understand the patient, and this may subject the patient to negligence by both doctors and nurses. They deny consumers their freedom of choice to decide whom to consult, where and when, at any point of the disease progress. With their practice, health care consumers like their cleanliness, knowledge as well as their accuracy.

Most nurses and doctors do not help patients in the night like in most clinics and private practices. It is only if the patient is declared an emergency that they can be attended to even in a hospital situation. This is unlike with a traditional healer who is always ready to help even when it is in the night.

6.4 A CALL FOR PARTNERSHIP BETWEEN TRADITIONAL HEALERS AND HEALTH PROFESSIONALS.

The rising incidence of diseases of unknown etiology and incurable diseases such as AIDS and cancer has led to traditional healers seeing more patients/clients who are continually disappointed with Modern medicine. Furthermore, traditional healers use empathy, sympathy and reassurance by keeping helpless clients/patients in their homes, when institutions like hospitals turn them away to await death at home. These two situations are facing the consumers of health today, and will continually

seek help one way or another.

If this gap between the two health systems (traditional and modern) is not bridged, the health consumers will continually be the one to suffer, and no service seems to be at the point of replacing another. It is necessary and obvious that partnership is the solution as both services are here to stay (Nzimakwe 1996:313).

6.4.1 Views of Health Professionals Regarding Partnership with Traditional Healers

They can add to the total number of the human resources by way of being incorporated into primary health care services e.g., in preventive, primitive, curative and rehabilitative services. In preventive and primitive health they can help in teaching their clients especially in the importance of immunization, HIV/AIDS, infant feeding, childhood diseases, communicable diseases, sexual transmitted diseases and many others.

Most of them promote breast-feeding more than health professionals. It becomes easier for them because clients suffering from sexual transmitted diseases, loss of libido, infertility as well as HIV/AIDS and others mostly consult them. Some appear to be good in treating mental illnesses, fear of unknown stress and depression.

6.5 CHALLENGES AND RECOMMENDATIONS

6.5.1 Challenges Facing Traditional Healers

Traditional healers in South Africa like in other African countries are facing a great change in response to developments in other parts of the social and economic system. This change has been brought about by economic modernization, which affect the way traditional practitioners operate. For

example, in Nigeria and Ghana traditional healers have begun to adopt many of the practices like dressing in white coats, and operating from modern clinical facilities. In Nigeria clinics have waiting rooms, and traditional healers use stethoscopes and keep record cards. This does not only bring competition between these two disciplines but also brings changes between the content of traditional healers (DeJong 1991:8).

Traditional practitioners are also becoming increasingly professionalized and specialized. They do refer cases to each according to their specialty. Furthermore DeJong (1991) stated that the development of professional associations is officially recognized and operating in 12 countries (DeJong 1991: 8).

It is necessary for traditional healers to include the formation of strong organizations to prevent exploitation and to share information and problems. The educational status of traditional healers should be improved so that they can understand issues affecting their practice. Skills such as business administration and financial management should be taught. Traditional healers should share opportunities with health professionals, such as claiming tariffs from the medical aid programs. They should attract more people to their organizations who might assist them in the transformation of traditional medicine in the African culture to a scientific endeavour. In addition, they should practice competently and truthfully so that the people in their community can trust them. They should be aware of professional secrecy and should keep in confidence all that pertains to their clients.

Traditional beliefs and customs must be recognized and taken into account at all times because they have an impact on the socio-cultural and environmental milieu of the people. Professionals who have been trained in the Western medicine should follow a policy of neutrality, allowing patients to go to the traditional healer while encouraging them to continue with the

particular treatment that they prescribed. Professionals such as nurses, doctors, psychiatrists need to learn more about the cultural background of their patients. Student nurses should be exposed to the community and psychiatric nursing science practice.

This exposure should include the traditional healers in the community. Workshops and seminars should be established at regular intervals for traditional healers and health care professionals to exchange information and experiences (Nzimakwe 1996: 315).

6.5.2 Challenges Facing Health Professionals

Educating modern health care personnel about traditional health care is necessary as health professional express a strong prejudice against traditional practitioners, and again seem to resist their integration into government-supported health care systems. This attitude is motivated by fear of competition and also by genuine mistrust of traditional methods of treatment.

One route to stimulate the interest of modern practitioners in the potential value of traditional health care is through modifications to their training. For example, in countries like China and Vietnam, traditional health is well accepted to the extent in such that their medical school curriculum incorporates traditional health care compulsorily. This constitutes a systematized body of knowledge about traditional health care to health professionals unlike in South Africa.

Other examples are; the University of Lagos in Nigeria, where medical students spend four to six weeks in rural areas with traditional healers. In Mali, students need to demonstrate knowledge of common traditional health practices. In Nigeria, Sokoto State, the six-year undergraduate medical

curriculum integrates traditional practitioners as tutors (DeJong 1991: 10-11).

South Africa as part of the African continent, should find a way of dealing with this challenge of integration of the two disciplines for the benefit of the client/patient. Trans-cultural nursing has to be included in the curriculum of the nursing courses as well as medical training. In-service training and workshops should be conducted for personnel who are working in close contact with the patient, e.g., nurses, doctors and paramedics.

6.5.3 Challenges Facing the Government.

Consideration regarding awareness, collaboration, training and legislation as well as acceptance of traditional health care system should be done.

Though some African governments have withheld formal recognition from traditional medicine, they are mostly aware of their contributions. South Africa like Ethiopia, Ghana, Mali, Nigeria, Niger, Senegal and Zaire should also establish institutes of traditional medicine for research and provision of therapeutic services. Five African countries have started involving traditional practitioners in their national health care systems: Zimbabwe, Liberia, Ghana, Nigeria, Sierra Leone, and Botswana, though Zimbabwe and Nigeria are expanding the role of traditional medicine most.

One of the obligations of the government is that of ensuring that people are in the process of being cared for, are free from any physical, social, spiritual and psychological harm by any means what so ever. This obligation does not create room for the government to simply ignore traditional health care, that is leaving them unrecognized, unregulated, but free to respond to demands for their services by their consumers. It becomes a necessity for the government to create strategies of supervising and training traditional healers, or regulate traditional health care practices. Furthermore, it also

calls for traditional health manpower development and service expansion. Ignoring traditional medicine frustrates the exchange of information between modern health care and traditional practitioners (DeJong 1991: 8-9).

The government should formulate a policy to make collaboration a reality at the central, the provincial and the district levels. The policy should have clear guidelines such as, licensing of traditional healers. Clear guidelines on how a referral system works, and this must be communicated to participants. Codes of conducts and regulations regarding traditional health care practice as well as a legal control body should be put in place.

- Disciplinary procedures.
- Patients' Rights Charter.
- Magnetization of fees to be paid by patients.

Guidelines of the plan of the building were the practice will be instituted should be there to prevent overcrowding, cross-infection, poor ventilation, poor sanitation as well as congestion of services with lack of privacy (Troskie 1995: 33; DeJong 1991: 9).

6.5.4 General Recommendations

Total inclusion should be considered because the more gap each discipline creates between itself and the other (traditional and modern), the more of clients will be exposed to harm. Even if history shows that the struggle, of whether inclusion will work has been on, it does not declare that because attempts have failed before, it is destined to fail always. This delay makes us focus more on finding solutions rather than (Freeman and Motsei 1990: 14).

6.5.4.1 Awareness programme

It is necessary for health professionals to be taught anthropology and how culture affects people's daily lives, decision making and freedom of choice. Traditional healers on the other hand should be taught amongst others:

- Personal and environmental hygiene including the use of clean equipments
- Methods of sterilization of utensils, e.g., boiling method, soaking etc
- Use of one razor blade on each patient
- Lectures on proper nutrition, well balanced diet for children and weaning should be given
- About cases for referrals to the clinic or hospital, e.g., Tuberculosis, bleeding, fractures, big cuts and wounds that are failing to heal, child birth which they cannot handle unless if they are trained as a traditional birth attendant.

6.5.4.2 Utilization of traditional healers

Traditional healers as part of health manpower can still be fruitfully utilized at the primary level of intervention, as village health workers doing the following duties:

- health education on topics that they are taught e.g., breast feeding, measles, home care, care of diarrhea at home, importance of family planning, personal hygiene and many more.
- ambulatory TB treatment.
- home visits and geriatric home nursing.
- community diagnosis of patients hidden in their homes.
- act as liaison officers with the Primary Health Care centers and with clinic and Community Health Nurses.

6.5.5 Recommendation for Further Research

According to the researcher's deductions, a study could be conducted wherein a strong focus could be done regarding the involvement of traditional healers on maternal and child health. This is necessary because it seems as if women and children most often visit traditional healers, starting from preconception to old age.

Another study could be of participant observation on the daily execution of the traditional healer's skills during their disease intervention processes. It seems as if a lot is still unveiled before the two disciplines could start off on the same footing. It is also a necessity for the health professionals as well as the zoologists to form partnership and investigate with traditional healers different herbs, regarding their origin, effects, how they are preserved and their uses on different illnesses and diseases.

Table 6.1.

Comparison of traditional healers, health professionals and health care consumers

	TRADITIONAL HEALERS	HEALTH PROFESSIONALS	HEALTH CARE CONSUMERS
Awareness	All traditional healers are convinced that people know that they exist	More than half of the health professionals confirms the idea that they are aware of the existence of traditional healers	All health care consumers confirm that traditional healers do exist
Collaboration	All traditional healers feel that it is necessary for them to be taken as part of the total health care system and that they can work hand in hand with other health care professionals	The majority of health professionals disagree with the idea of collaboration of traditional healers and health professionals. Most health professionals disagree to the fact of traditional healers visiting their patients while hospitalized	Few health care consumers agree that collaboration of the two systems be certain whereas more than half disagree
Acceptance	More than half of the total sample agree that the are well accepted by people	The majority of health professionals do accept the fact that traditional healing system is a reality and there are some of the diseases that can be treated by traditional healers	Very few health care consumers did visit the traditional healers, use traditional medicine nor need traditional healers. In conclusion more than half of the total sample disregard the idea
Legalization	The majority of traditional healers want to be registered for several reasons, and all traditional healers want to be regarded as health professionals	The majority of health professional want traditional to be legalized	More than half of the total sample agree that traditional healers be legalized
Training	The majority of traditional healers confirms the fact that they are trained by their sangomas', diviners and faith healers - Again most of them revealed the fact that they do not need formal training as this is a call not a wish.	Idea not demanded	Idea not demanded
Referral	Looking at Table 5.2 above a list of diseases reflect the fact that traditional healers do have a need for referring patient to modern health care system	Health professionals see the need for referral to traditional healers though the researcher concluded they mostly referred to faith healers not other types of traditional healers	When asked whether they felt any need while hospitalized seeking traditional healers all responded negatively

Table 6.2.

Similarities and differences between Folk and Scientific Health Care systems

SIMILARITIES			
The Folk Health System		The Scientific Health System	
*	Both systems employ similar diagnostic techniques including observation and listening.	*	Both systems use medicinal substances and employ some form of laying on of hands the care of the sick.
*	Both systems make use of verbal and nonverbal communication techniques.	*	Both systems are based on assymetric relationships between experts and laypersons.
*	Both systems engage in the naming of illnesses and the creation of positive expectations.	*	Both systems provide an explanation of disease, a rationale for treatment, and a rationale for social and moral norms.
*	Both systems employ suggestion, interpretation, emotional support, and manipulation of the environment as therapeutic modalities.		

DIFFERENCES			
The Folk Health System		The Scientific Health System	
*	Takes into account the religious and social implications of disease	*	Focuses primarily on the personal implications of disease
*	Does not make a definite distinction between mental and physical illness	*	Makes a definite distinction between mental and physical illness
*	Oriented to the community	*	Oriented to the individual
*	Takes place in familiar surroundings	*	Takes place in unfamiliar surroundings
*	Emphasizes humanistic care	*	Emphasizes impersonal care
*	Emphasizes familiar, practical, and concrete facts	*	Provides fragmented care
*	Provides holistic care	*	Emphasizes curing
*	Emphasizes caring	*	Stresses diagnosis and treatment
*	Stresses prevention	*	Does not emphasize cultural support
*	Emphasizes cultural support	*	High cost for care
*	Moderate cost for care		

Source: (Clark 1992: 328)

Table 6.2 above shows that there are similarities as well as differences between Folk health care and Professional health care systems. When the health practices followed by individual members of a culture are not successful and illness results, there is usually a need to seek assistance from another health care provider (Clark 1992:326).

6.6 CONCLUSION

Out of the data gathered and the analysis done so far, it is clear that if something is not done to bridge this chasm between traditional healing and modern practices, health care consumers will continually be victims of circumstances. It is through this qualitative research that clarity has been made.

BIBLIOGRAPHY

Abo, T. 2000. Operationalizing the right of indigenous peoples to self-determination. Finland: Institute for Human Rights.

Aderibigde,A.O., Emudianughe,T.S.& Lawal, B.A.1999. Anti-hyperglycaemic effect of Mangifera indica in rat. Vol. 13. Number 6: 504-507.

Akah, P.A. Orisakwe, O.E; Gamaniel, K.S. and Shittu, A. 1998. Evaluation of Nigerian Traditional Medicines:Effects of Some Nigerian Folk Remediew on Peptic Ulcer. Journal of Ethnopharmacology Vol. 62 Number 2: 123-127.

African National Congress, 1994 (a). A National Health Plan for South Africa. Johannesburg: South Africa. Umanyano Publications.

African National Congress, 1994 (b). The Reconstructive and Development Programme. Cape Town: Umanyano Publications.

Bellakhdar, J. 1989. A New Look at Traditional Medicine in Morocco. World Health Forum. Vol.10: 193-199.

Blackett-Sliep, Y. 1989. Traditional Healers and the Primary Health Care Nurse; Nursing RSA, Vol. 4: No .11, p: 42-45.

Bodibe, W.J.M. 1988. The Inclusion of Traditional Healers in Mental Health Team A Social Perspective: UNISA.

Brink, P.J. & Wood, M.J. 1998: Advanced Designs in Nursing Research. California: Sage Publishers.

Budhiraja, S.S., Cullum, M.E., Sioutis, S.S. Evangelista, L. Habanova, S.T. (1999) Biological activity of Melaleuca alternifola oil component...Journal of Manipulative Physiological Therapy. Vol. 22 No. 7: 447-453.

Carnwell, R. 1997. Evaluative Research Methodology in Nursing and Healthcare. London: Churchchill Livingstone.

Clark, M.J. 1992. Nursing in the Community.
Norwalk: Appleton & Lange.

Dalziel, Y. 1992. Health Promotion; the Community Development Approach.
Health Visitor; 65, 7: 228-229.

De Jong, J. 1991. Traditional Medicine in Sub-Saharan Africa.
Its Importance and Potential Policy Options.
Pretoria: Academia Publishers.

Department of Health, 1999: Patients' Rights Charter: Quality Assurance.
Pretoria: Government Printers.

Eland, P. 1996. "Naledi" Swops the Stethoscope for the Bones.
City Press. September, 6.

Erlandsson, A.L.,Backman, B. Stenstrom, A. & Stecksen-Blicks,C. 2001.
Conscious sedation by oral administration of midazolam in paediatric dental treatment. Swedish Dental Journal. Vol. 25. No. 3: 97-104.

Freeman, & Motsei, M. 1990: Is there a Role for Traditional Healers in Health Care in South Africa . Johannesburg: University of Witwatersrand.

Gay, L.R. 1992. Educational Research: Competencies for Analysis and Application. 4th Ed. New York: Merrill.

Grierson, D. S. & Afolayan, A.J. 1999. An ethnobotanical study of plants used for the treatment of wounds in the Eastern Cape, South Africa
Journal of Ethnopharmacology Vol 67 No. 3: 327-332.

Hammond-Tooke, W.D. 1972. The structuring of chaos: anthropological approaches to the human mind. Johannesburg: University of Witwatersrand Press.

Helvie, C.O. 1998: Advanced Practice Nursing in the Community.
London: Sage Publishers.

Jackson-Meadow cited in Vontress, C.E. 1991. Traditional Healing in Africa: Implication for Cross-Cultural Counselling, Journal of Counselling and Development. 70(1): 240-249.

Kimura, I; Nakashima, N; Sugihara, Y; Fu-jun, C, and Kimura, M 1999. The Antihyperglycaemic Blend Effect of Traditional Chinese Medicine Byakko-to on Alloxan and Diabetic KK-CA mice. Phytother-Res. 13(6) 484-8

Khupiso, V. 1996. Healers Learn a New Art. Sunday Times. October 6.

Klein, N. 1979. Culture, Cures, and Contagion.
Novajo California: Chandler & Sharp Publishers.

Leininger, M.M. 1991: Culture Care Diversity and Universality: A Theory of Nursing. New York: National League for Nursing Press.

LoBiondo-Wood, G. & Harber, J. 1994: Nursing Research, Methods, Critical Appraisal and Utilization. Baltimore: Mosby.

Loustraunau, M.O. & Sobo, E.J. 1997: The Cultural Contexts of Health, Illness, and Medicine. Westport, Connecticut: Bergin & Garvey Publishers.

Maddox, J.L. 1977. The Medicine Man.
New York: AMS Press Publishers.

Matjila, J. 1988: The Role of the Traditional Healer in Community Health Care. Paper Presented to A Workshop on Public Health, Social Services and the Law: Pretoria: University of South Africa.

Mbiti, J. S. 1991. Introduction to African Religion. (2nd ed.).
Clay Limited. Bungay: Suffolk.

Michele, J. 1995: A Swazi Nursing Perspective on the Role of Indigenous Healer: Journal of Cultural Diversity. Volume 16 Number 18.

Miles, M.B. & Huberman, A.M. (1994): Qualitative Data Analysis. 2nd Ed. London: Sage Publications.

Neuman, O. 1990. Relationships between perception and action: current approaches. Berlin New York: Springer-Verlag.

Onuaguluchi, G. and Nwafor, P. 1999. Pharmacological Basis for the Use of the Antivenene Soluble Extract of Diodia Scandens as a Laxative, Oxytocic Agent and a Possible Aphrodistiac in Traditional Medicine Practice in Eastern Nigeria. Phytother-Res. 13(6): 459-63.

Polit, D. F. & Hungler, B. P. 1993. Nursing Research Principles and Methods. 4th Ed. Philadelphia: Lippincott.

Speight, S. T.; Myers, L. J.; Cox, C. I. & Highlen, P.S. 1991 cited in Vontress, C.E. 1991. Traditional Healing in Africa: Implication for Cross-Cultural Counselling, Journal of Counseling and Development, 70(1): 29-36.

Stanhope, M. & Lancaster, J. 1992. Community Health Nursing Process and Practice for Promoting Health. St Louis: Mosby.

Staugard, F. 1985. Traditional Medicine in Botswana. Gaborone: Ipelegeng Publishers.

Talbot, L.A. 1995. Principles and Practice of Nursing Research. Baltimore: Mosby.

Thailia, E. 1995. To Be a Nurse ... And a Sangoma ... Is to Know the Best of the Two Worlds : Nursing News, June: 36-40.

Troskie, R. 1995. The Role of the Nurse in Collaborating with Traditional Healers in Primary Health Care clinics. Health/Gesondheid, Rand Afrikaanse Universiteit.

Upvall, M.J. 1995. A Swazi Nursing Perspective on the Role of Indigenous Healers. Journal of Cultural Diversity Vol.2, No 1: 16-19.

Van Rensburg, H.C.J, Fourie, & Pretorius, E. 1992. Health Care in South Africa. Pretoria: Academica.

Vontress, C.E. 1991. Traditional Healing in Africa: Implication for Cross-Cultural Counselling, Journal of Counselling and Development. 70(1): 240-249.

Whaley, F.L. & Wong, D.L. Third Edition. Nursing Care of Infants and Children. U.S.A.: Mosby

Willcox, M.L. 1999. A Clinical Anti-Malarial Agent: A Ugandan Herbal Remedy for Malaria. Journal Public Health Medicine.
Vol. 21 Number 3: 318-24.

World Health Organization. 1978. Traditional Medicine and its Role in the Development of Health Services in Africa. AFRO Technical Paper No. 12. African Regional Office Brazzaville: World Health Organization.

World Health Organization. 1990. Achieving health for all by the year 2000. midway reports of country experiences. Vol. 262. p.:ill. Geneva.

APPENDIX A

LETTER OF INTENT

APPENDIX A

PRIVATE BAG
DZANANI
0975
LIMPOPO

30 September 2002

Limpopo Region Provincial
Department of Health

APPLICATION TO CONDUCT RESEARCH ON TRADITIONAL HEALING AS A HEALTH CARE DELIVERY SYSTEM IN A TRANSCULTURAL SOCIETY

I hereby apply to conduct a research on the above topic, my research proposal has been accepted by UNISA.

My Supervisor is Prof. O.N. Makhubela-Nkondo and her telephone number is (012) 429 6257.

The results, findings and recommendations may be utilized for future policy formulation and will be made available upon completion.

Yours sincerely

Bereda

Ms. J.E. BEREDA

APPENDIX B

STRUCTURED QUESTIONNAIRES OF TRADITIONAL HEALERS, HEALTH PROFESSIONALS AND HEALTH CONSUMERS

APPENDIX B

QUESTIONNAIRE

INSTRUCTION:

Please mark the appropriate box ☑

Section A: To be completed by all participants

Section B: To be completed by traditional healers

Section C: To be completed by health professionals

SECTION A: DEMOGRAPHIC INFORMATION

1. Age

0-25	
26-35	
36-45	

Other, _____

2. Gender

Male	
Female	

3. Race

Black South African	
White South African	

Other, _____

4. Marital status

Married	
Single	
Widowed	
Divorced	

Other, _____

5. Educational level

Not educated	
STD 0-5	
STD 6-10	
Diploma	
Degree	

6. Religion

Christianity	
Hindu	
Islamic	
Cult (Magicians)	

Other, _____

7. Occupation

Unemployed	
Doctor	
Nurse	
Paramedic	
Labourer	

Other, _____

SECTION B: TRADITIONAL HEALERS

1. Do you think the community (people) know that you exist?

Yes	
Uncertain	
No	

2. Do people come seeking your help?

Yes	
No	

3. Is it important for you to be registered?

Yes	
No	

Why _____

_____

_____

4. Do you think you must be regarded as a Health Professional?

Yes	
No	

5. Do you think it is necessary for your services to be regarded as part of the total health care system?

Yes	
No	

6. Can you work hand in hand with nurses, doctors and other health care professionals?

Yes	
No	

7. Do other health professionals accept your practice?

Yes	
No	

Why?

_____
_____
_____

8. Do you think your practice needs training in an institution for certification?

Yes	
No	

Why? _____
_____
_____

9. Can you list diseases that can best be treated by you or other traditional healers?

_____
_____
_____
_____

10. Which diseases will you refer straight to the hospital?

_____
_____
_____
_____

11. Can you openly show other health professionals how you operate?

Yes	
No	

12. How do you acquire this knowledge and skills to be able to help people with illness?
State:

_____
_____
_____

13. Do you get some form of training before you practice as a traditional healer?

Yes	
No	

If yes for how long? _____

14. How best can you work as a team with other health professional?
Explain:

_____
_____
_____

15. Give your comment regarding the importance of your practice

_____
_____
_____
_____

SECTION C: HEALTH PROFESSIONALS

1. Do you think traditional health system is to be regarded as an important health care facility in any society?

Yes	
No	

2. Do you believe that other diseases need traditional healers?

Yes	
No	

3. Because you are one of the multi-disciplinary team, can you accept a traditional healer in this team?

Yes	
No	

4. If your answer of number 2 is yes, can you list diseases that you feel need traditional healing.

_____

_____

_____

5. While in hospital situation, did you ever came across a situation where a patient needed traditional healers or relatives demanding discharge of their family member for traditional health care?

Yes	
Uncertain	
No	

6. Do you want traditional healers to be legalised?

Yes	
Uncertain	
No	

7. If the answer in Question 6 is Yes, will you suggest referrals to and from these people?

Yes	
No	

8. If you are a nurse, doctor or paramedic etc., in your practice will you accept traditional healers to come and visit their patients?

Yes	
Uncertain	
No	

9. Is there anything you are not in favour of with traditional healing?

Yes	
No	

If yes, state briefly

_____

_____

_____

10. Do you know of any person who was completely cured by a traditional healer?

Yes	
No	

If yes, can you defend this practice, state briefly:

_____

_____

_____

11. Do you think traditional healing practice is fading way?

Yes	
No	

Why?

_____

_____

_____

12. Give your general comment regarding traditional healing practice and their inclusion into the mainstream of health care ministry.

SECTION D: HEALTH CONSUMERS

1. Have you ever visited a traditional healer?

Yes	
No	

2. Have you ever used traditional medications for any sickness?

Yes	
No	

3. Do you think you will ever need a traditional healer in your life?

Yes	
Uncertain	
No	

4. Do you prefer a traditional healer over medical doctors?

Yes	
Uncertain	
No	

5. List diseases that you feel can best be treated by traditional healers

_____

_____

_____

6. While hospitalised did you ever feel the need to try traditional healers?

Yes	
No	

7. Will you be happy if traditional healers can be members of the health team both in hospital and in the community?

Yes	
Uncertain	
No	

8. Do you want traditional healing to be legalised?

Yes	
Uncertain	
No	

9. Do you support the idea of allowing traditional healers to visit their patients in the hospitals?

Yes	
Uncertain	
No	

10. Comment/ Explain your personal view with regard to Traditional healing

_____

_____

_____

APPENDIX C

LETTER OF APPLICATION FOR PERMISSION TO UNDERTAKE THE STUDY (NORTHERN PROVINCE)

APPENDIX C

P.O. BOX 1512
DZANANI
0955

THE SUPERINTENDENT GENERAL
DEPARTMENT OF HEALTH
PIETERSBURG
0700

RE: REQUEST FOR CONDUCTING RESEARCH IN THE NORTHERN PROVINCE

The above matter refers:

I am a Chief Professional Nurse stationed at Siloam hospital and currently a master's degree student at the University of South Africa. I intend to obtain relevant information with regard to Traditional healing as a health care system in a multicultural society.

The participants will include traditional healers, health professionals as well as health care consumers.

The study may empower traditional healers to can openly conduct their care to those that need their service as well as referring patients to the hospital where necessary.

In this regard I here wish to request a written permission to use when visiting the participants.

Enclosed herein please find my research proposal, questionnaire and a letter from the ethics committee for reference.

Thanking you in advance.

Yours faithfully

JE Bereda
Community Nursing Science Researcher

APPENDIX D

REPLY FROM NORTHERN PROVINCE DEPARTMENT OF HEALTH TO COME AND MAKE A PRESENTATION

NORTHERN PROVINCE

DEPARTMENT OF HEALTH AND WELFARE

TEL: (015) 290 9000
(015) 290 9001
FAX: (015) 291 5961
(015) 291 5146

Enquiries: Sinah Mahlangu.

PRIVATE BAG X9302
PIETERSBURG
0700

Reference: Research and Quality Improvement

31 August 2000

Box 1512
Dzanani
0955

JE Bereda

TRADITIONAL HEALING AS A HEALTH CARE DELIVERY SYSTEM IN A TRANSCULTURAL SOCIETY

1. Permission is hereby granted to conduct a study on the above topic in the Northern Province.
2. The Department of Health & Welfare needs a copy of the research findings for its own resource centre.
3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible.
4. Implications: Permission should be requested from regional and institutional management to do research.

Sincerely,

SUPERINTENDENT _ GENERAL

DEPARTMENT OF HEALTH & WELFARE

NORTHERN PROVINCE

APPENDIX E

PATIENT'S RIGHT CHARTER

PATIENTS RIGHTS CHARTER

INTRODUCTION

For many decades the vast majority of South African population has experienced either a denial or violation of fundamental human rights, including rights to health care service.

To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No. 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this **PATIENTS' RIGHTS CHARTER** as a common standard for achieving the realisation of this right.

PATIENTS RIGHTS

1. Healthy and safe environment

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection form all forms of environmental danger, such as population, ecological degradation or infection.

2. Participation in decision-making

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision making on matters affecting one's health.

3. Access to health care

Everyone has the right of access to health care services that include:

(i) Receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;

(ii) Treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

(iii) Provision for special needs in the case of new born infants, children, pregnant women, the aged, disabled person, patients in pain, persons living with HIV or AIDS patients;

(iv) Counseling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

(v) Palliative care that is affordable and effective in cases of incurable or terminal illness;

(vi) A positive disposition displayed by health care workers that demonstrates courtesy, human dignity, patience, empathy and tolerance;

(vii) Health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

4. Knowledge of one's health insurance/medical aid scheme

A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to

challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

5. Choice of health services

Everyone has a right to choose a particular health care for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers of facilities and the choice of facility is in line with prescribed service delivery guidelines.

6. Treatment by a named health care provider

Everyone has a right to know the person that is providing health care and therefore must be attended to by only clearly identified health providers.

7. Confidentiality and privacy

Information concerning one's health including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of court.

8. Informed consent

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of theses elements.

9. Refusal of treatment

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

10. A second opinion

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

11. Continuity of care

No one shall be abandoned by a health care professional worker or a health facility that initially took responsibility for one's health.

12. Complaints about health services

Everyone has the right to complain about the health care and to have such complaints investigated and receive a full response on such investigation.

RESPONSIBILITIES OF THE PATIENT

Every patient or client has the following responsibilities:

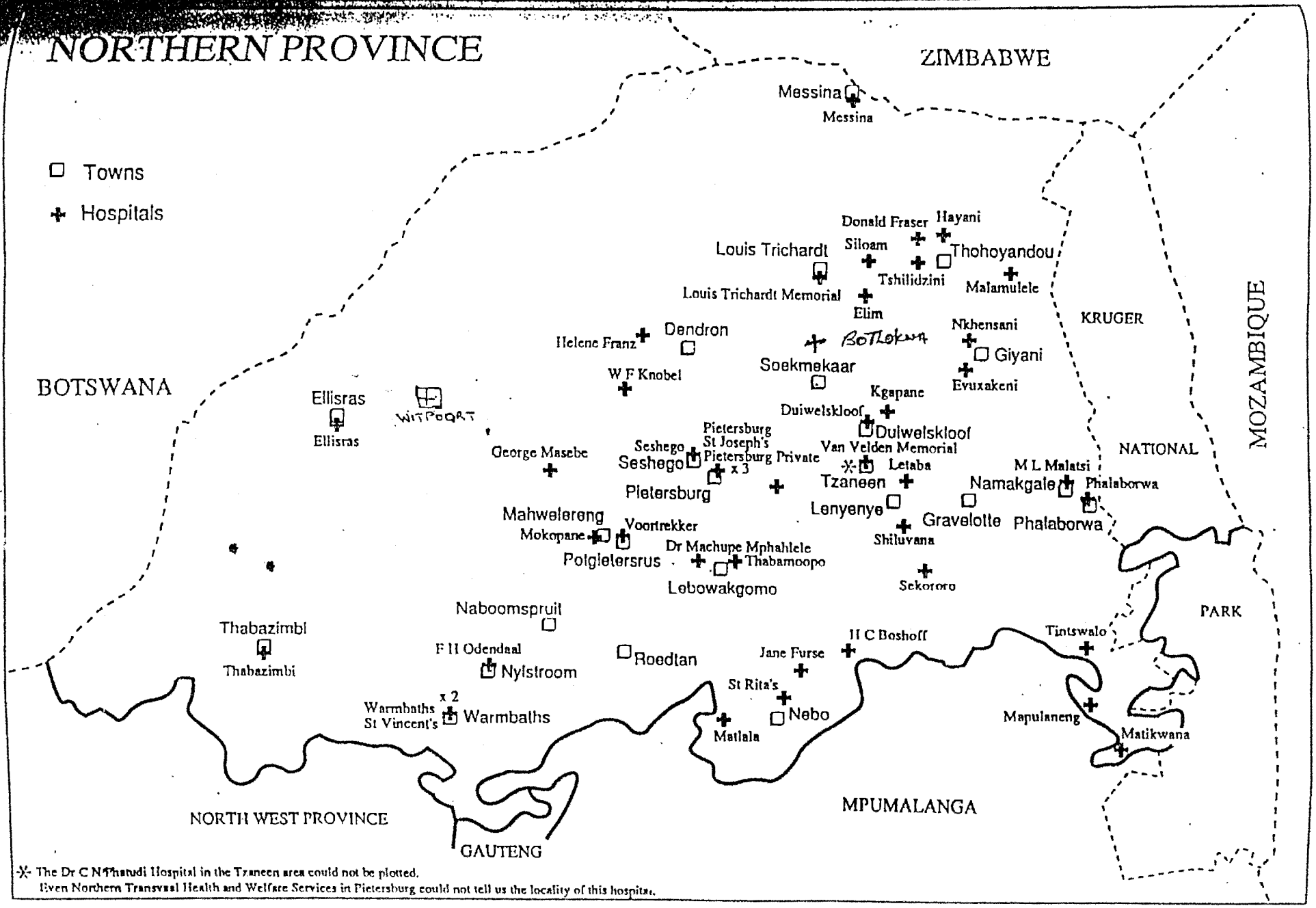
1. To take care of his or her health.
2. To care for and protect the environment.
3. To respect the rights of other patients, health workers and health care providers.
4. To utilise the health care system optimally and not to abuse it.
5. To know his or her local health services and what they offer.
6. To provide health workers with relevant and accurate information for

diagnostic, treatment, rehabilitation or counseling purposes.

7. To advise the health providers of his or her wishes with regard to his or her death.
8. To comply with the prescribed treatment and/or rehabilitation procedures.
9. To enquire about the related costs of the treatment and/or rehabilitation and to arrange for the payment.
10. To take care of health records in his or her possession.

APPENDIX F

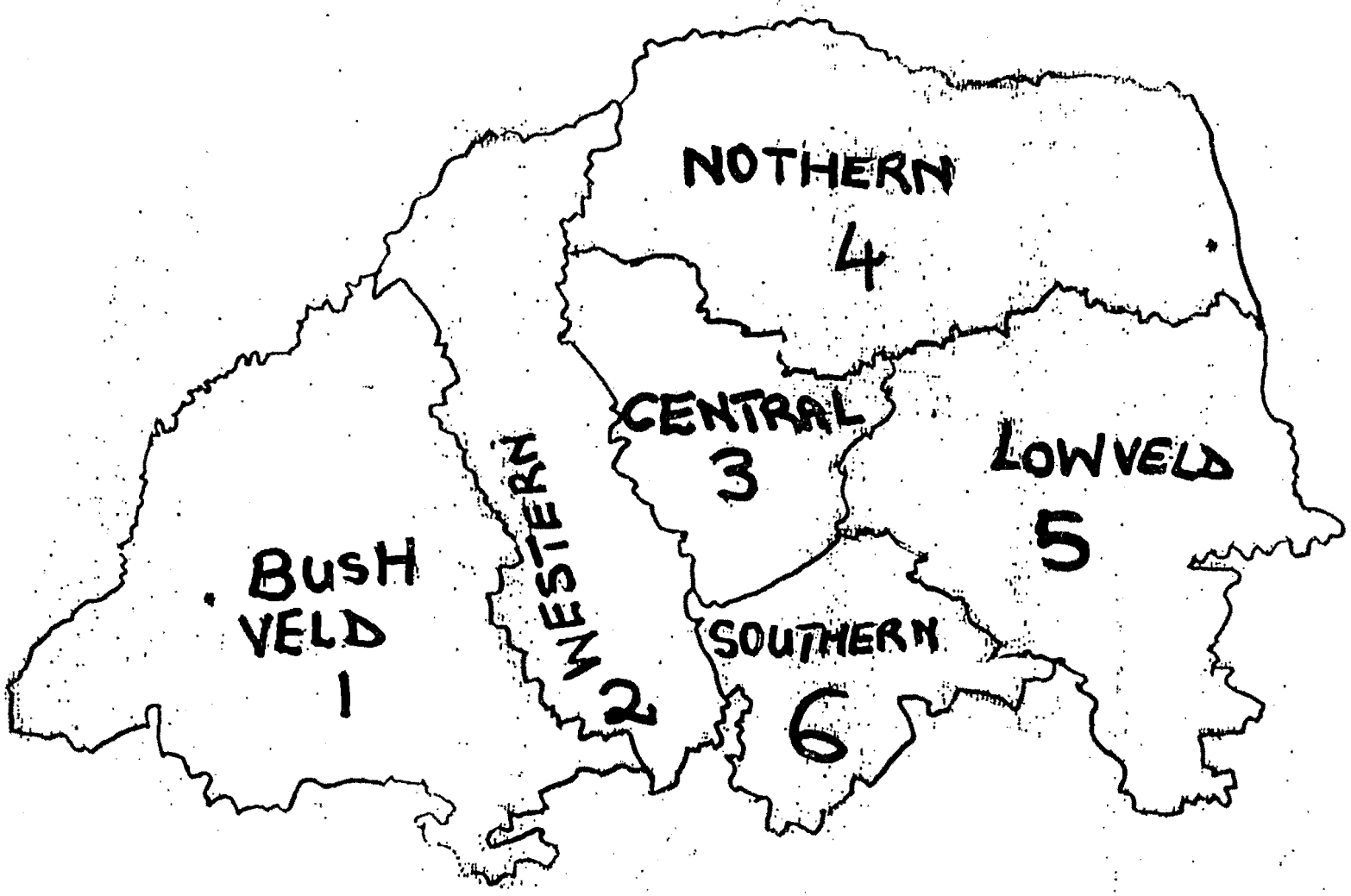
MAP OF THE NORTHERN PROVINCE INDICATING HOSPITALS, CLINICS AND HEALTH CENTRES



The Dr C N Phatudi Hospital in the Tzaneen area could not be plotted.
Even Northern Transvaal Health and Welfare Services in Pietersburg could not tell us the locality of this hospital.

APPENDIX G

MAP OF THE NORTHEN PROVINCE INDICATING REGIONS


NOTHERN
4
CENTRAL
3
LOWVELD
5
BUSH
VELD
1
WESTERN
2
SOUTHERN
6