Views on traditional healing: Implications for integration of traditional healing and Western medicine in South Africa

by

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Summary

There are two independent streams of health care in South Africa: traditional healing and Western medicine. Proposals to formally integrate the two streams have been made by the World Health Organization and by the South African Department of Health.

In this study, the philosophical background behind each of the two health care models is discussed, as well as literature on the possible integration of the two systems. It has not been clear if Western-trained health-care practitioners would be prepared to work with traditional healers. The purpose of this study was therefore to examine health care practitioners' *opinions, attitudes, knowledge* and *experiences* with traditional healers, and to determine to what extent these variables would predict their *intentions* to work with these healers.

A Within-Stage Mixed Model design was used, and data were collected using a self-developed questionnaire. A total of 319 health care practitioners from State hospitals and clinics in Gauteng and Limpopo provinces participated in the study.

The results of the study revealed significant differences between groups of health care practitioners in terms of their *opinions, attitudes, experiences* and *intentions* to work with traditional healers. Psychiatric nurses and psychiatrists showed more positive opinions, more positive attitudes, more knowledge and more willingness to work with traditional healers than do general nurses and physicians. Psychiatric and general nurses also had more experiences with traditional healing than did psychiatrists and physicians. The results also revealed that *attitudes, knowledge, opinions* and *experiences* predict Western health care practitioners' intentions to work with traditional healers, with *attitudes* being the strongest and *experiences* the weakest predictors.

Health care practitioners' views of traditional healing were contradictory and ambivalent in many instances. This implies that integration of the two health care systems will be complex, that the current potential to integrate the systems is weak and that such integration can only be realised with considerable effort from all stakeholders.

Key words:

Traditional healing; Western healing; Health care practitioners; Opinions; Attitudes; Knowledge; Experiences; Intentions; Traditional healing/Western medicine integration.

Student number: 44741316

I declare that - '**Views on traditional healing: Implications for integration of traditional healing and Western medicine in South Africa' –** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____ 29 November 2012

SIGNATURE DATE

(Mr) Maboe Gibson Mokgobi

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CHAPTER ONE

INTRODUCTION

1.1 CONTEXTUALISING THE THESIS

For centuries, traditional African healing has played an important role in the health care system in South Africa and elsewhere on the African continent. In his opening statement of a doctoral thesis that looked at the links between Western psychotherapy and traditional healing, Rudnick (2002) mentioned that the philosophies of health care in South Africa tend to be based on either the modern approach or the traditional approach. The former is based on the Western medical model and the latter on indigenous belief systems (Dagher & Ross, 2004). Lazarus (2006), on the other hand identified, yet another approach which is called 'the allied' approach. According to her, this approach includes complementary and natural health.

Research in the traditional healing area has estimated that between 70% and 80% of black people in South Africa in rural and in urban areas consult with traditional healers before going to hospitals and clinics, or to private doctors (Bodibe, 1993; Ramgoon, Dalasile, Paruk & Patel, 2011). The World Health Organization shares this estimate and has also added that over 70% of people in many developed countries have also used some form of alternative medicine such as acupuncture (World Health Organization, 2008). Although it has always been the case that the majority of people use traditional healing, the colonial authorities and the apartheid government in South Africa did not recognise the efficacy of this form of healing. It was only after the democratic elections of 1994 that the South African government started to look at the possibility and viability of integrating the two health care systems. Deliberations on how to go about effecting the integration are still ongoing, approximately eighteen years into the new democratic dispensation.

More recently, talks about the proposal by the national Department of Health to have traditional African healing work side by side with mainstream (Western) medical practice in state hospitals and clinics in South Africa seem to have gained some momentum. This comes about as a result of, among other things, the majority of black people using the services of traditional healers as mentioned earlier; and traditional healers fighting for recognition by the

Health Professions Council of South Africa (HPCSA), medical aid schemes and other authorities concerned with health care in South Africa.

The proposal to integrate Western healing with traditional African healing has been met with both acclamation and harsh criticism from different quarters of the South African society. One of the challenges for integration is whether Western-trained health care practitioners such as general practitioners (general physicians), psychiatrists, general nurses and psychiatric nurses would embrace traditional African healers. The present study looked specifically at Western-trained health care practitioners' opinions of, attitudes towards, knowledge of and experiences with traditional African healing and at how those opinions, attitudes, knowledge and experiences may impact on the proposed integration of the two health care models. The study planned to tease out opinions and attitudes that could inform, in part, the success or failure of the proposed integration of the two health care perspectives. This plan was influenced by Tabuti, Dhillion and Lye (2003) who believed that attitudes and opinions determine the viability of integration. For the purposes of clarity, it should be noted that this study did not focus on traditional healers' opinions and attitudes towards Western medicine because the purpose of the study was not to provide a model for integration of traditional healing and Western medicine but rather to discuss implications for possible integration of the two systems, based on Western-trained health care practitioners' views of traditional healing.

The author of this thesis was, however, well aware of the fact that opinions and attitudes alone would not determine the success or failure of the proposed integration. Other factors that were not within the scope of the thesis would be critical in determining the outcome of the proposed integration. For instance, the accreditation of traditional healer trainers, the registration of traditional healers and testing of the efficacy of traditional medicine are highly complex issues that need to be meticulously investigated; as Ensink and Robertson (1999) pointed out, traditional healers in South Africa have no national organisation which regulates entry into the profession and sets training standards.

1.2 RATIONALE FOR THE STUDY

South Africa is experiencing a dearth of qualified health care practitioners, a problem that existed even before the political liberation in 1994. Rural state hospitals and clinics have

arguably never had enough health care personnel. As if the scarcity of qualified health care personnel is not enough to put enormous strain on the system, many nurses and highly qualified and experienced doctors, that the country desperately needs, continue to move abroad at an alarming rate. Consequently, state hospitals and clinics are undesirably understaffed, and health care personnel in these facilities execute their duties with limited operational resources.

In his April 2008 article '*Giving aspirin for cancer'* in *City Press*, Mooki (2008) revealed that one of the top Gauteng provincial hospitals had been without vital antibiotics normally used for the treatment of meningitis. He further stated that doctors at Helen Joseph Hospital in Johannesburg reported that this hospital had run out of *Amphotericin B*, an antifungal drug used for the treatment of systemic fungal infections and often prescribed to patients with HIV-related infections. This revelation was not surprising, and there have been similar reports in other provincial hospitals in the past ten years or so. They attest to the dire state of some of the country's state hospitals and clinics in both rural and urban areas. Poor people, who are in the majority and who cannot afford the high fees that the private health care facilities charge, are in such instances left to fend for themselves. For them, good health care remains far-off.

In this state of affairs, a solution has to be sought. Several approaches could be considered for dealing with this problem. One, the subject of this thesis, is to look at the feasibility of integrating the traditional African and the Western health care models. This is suggested because apart from the abovementioned reasons, according to the 2007 mid-year population estimates as well as the 2011national census, nearly eight out of ten (79.6% and 79.2% respectively) people in South Africa were classified as African (Statistics South Africa, 2007; Statistics South Africa, 2012) and between 70% and 80% of Africans utilise the services of traditional African healers for various physiological, psychiatric and spiritual reasons (Abdullahi, 2011; Bodibe, 1993). This, therefore, necessitated an investigation into health care practitioner's opinions of, attitudes towards, knowledge of and experiences with African traditional healing. With this in mind, this study aimed to contribute to the current debate about the possibility of the integration of the two health care perspectives in state hospitals and clinics in rural and urban South Africa.

1.3 CONCEPTUAL CLARIFICATION

For the purposes of clarity, it is essential to deal with some core terminologies used throughout the thesis.

- The term '**traditional African healing'** will be used interchangeably with the term **'traditional healing'** to mean the health care model that is not part of the orthodox Western health care one. For the purposes of this thesis, the term African refers to the indigenous people of Africa.
- '**Western health care practitioners**' mean those who have been trained in universities and other institutions that use Western training or scientific methods. These are professionals such as medical doctors and nurses. They will occasionally be referred to as mainstream or orthodox in this thesis. In addition, the terms 'Western healing' and 'Western medicine' will also be used interchangeably.
- For the purposes of data collection and subsequent analysis, this study differentiated among health care practitioners such as **physicians**, **psychiatrists**, **general nurses** and **psychiatric nurses**. The term 'general physicians' will occasionally be used to refer to the physician category.
- **'Integration'** refers to the formal collaboration between the African and the Western medical models.
- **'Opinions'** refers to Western-trained health care practitioners' views about traditional African healing.
- **'Attitudes'** refers to the degree of positive or negative affect associated with traditional African healing. This is what Thurstone (1928) called one's feelings about a particular topic.
- **'Knowledge'** refers to the information that Western health care practitioners have about traditional healing.
- **'Experiences'** refers to those which are direct (through collaborating, consulting or having collaborated and consulted with traditional African healers in the past) or indirect (through experiencing traditional African healing through the experiences of patients of orthodox medical practitioners as well as the experiences of people related to the health care practitioner).

- **'Behavioural intentions'** refers to the intent to make use of traditional healing in the future. This could be in the form of collaboration with traditional healers and/or consulting traditional healers for medical or spiritual purposes.

1.4 AIMS OF THE STUDY

Within the Southern African Development Community (SADC) region, several studies have been carried out into different perceptions of traditional healing, with some investigating health care professionals' perceptions of the integration of the Western and traditional African health care system (Hopa, Simbayi & du Toit, 1998; Straker, 1994; Upvall, 1992). Mixed results were found. Some health professionals seemed to lean more towards informal co-operation whilst others supported more formal co-operation between the two systems (Hopa et al., 1998); and others were ambivalent (Mngqundaniso & Peltzer, 2008; Upvall, 1992). It was therefore the objective of the present study to develop further insights into this area of traditional healing by looking at the opinions, attitudes, knowledge and experiences of health care practitioners in the Gauteng and Limpopo provinces of South Africa.

The aims of the study were:

- To explore Western-trained health care practitioners' *opinions* of, *attitudes* towards, *knowledge* of and *experiences* with traditional African healing.

- To investigate how these factors impact on the practitioners' intentions to make use of the services of traditional African healers in the future.

- To investigate health care practitioners' demographic data (gender, religion and language) to determine if there were differences between groups in terms of their opinions, attitudes, knowledge, experiences and intentions to work with traditional healers in the future.

The assumption was that an understanding of Western-trained health care practitioners' opinions, attitudes, knowledge, experiences and intentions to work with traditional healers could contribute to guiding the proposed integration process, and its sustainability, in South Africa; and that health care practitioners, traditional healers, medical aid schemes, the South

African Department of Health, consumers of the traditional African health care system and other interested parties would benefit from the findings of the study.

1.5 RESEARCH QUESTIONS

The study was guided by the following research questions:

- Are there differences of opinions of, attitudes towards, knowledge of and experiences with traditional African healing among different groups of health care practitioners?[1]
- Are there differences among different groups of health care practitioners in terms of their intentions to work with traditional healers in the future?
- Do Western-trained health care practitioners' opinions of, attitudes towards, knowledge of and experiences with traditional African healing predict their intentions to work with traditional African healers in the future?

1.6 RESEARCH HYPOTHESES

The present study contains six key hypotheses:

Hypothesis 1: There would be significant differences between the four categories of health care practitioners in terms of their *opinions* of the traditional African healing system.

Hypothesis 2: There would be significant differences between the four categories of health care practitioners in terms of their *attitudes* towards the traditional African healing system.

Hypothesis 3: There would be significant differences between the four categories of health care practitioners in terms of their *knowledge* of the traditional African healing system.

Hypothesis 4: There would be significant differences between the four categories of health care practitioners in terms of their *experiences* with traditional African healing.

[1] The four categories of health care practitioners are psychiatrists, physicians, general nurses & psychiatric nurses.

Hypothesis 5: There would be significant differences between the four categories of health care practitioners in terms of their *intentions* to work with traditional African healers in the future.

Hypothesis 6: A significant proportion of Western-trained health care practitioners' *intentions* to work with traditional African healers will be explained by their opinions, attitudes, knowledge and experiences with the traditional African healing system.

1.7 DELINEATING THE THESIS

The thesis is divided into six chapters. Chapter One puts the thesis in context and specifies the aims, research questions and hypotheses.

Chapter Two further solidifies the foundation by giving a detailed discussion of the background to this study. This is done in order to foster a better understanding of the traditional African healing system as well as of the Western healing system. In this chapter, emphasis is placed on the relationship between traditional African healing and spirituality on the one hand and the traditional African religion on the other hand, because these aspects are considered to be inextricably linked (Gumede, 1990a). One cannot talk about traditional African healing without taking traditional African religion or spirituality into account. Towards the end of the chapter, traditional healing and Western healing are juxtaposed to show the differences between the two healing systems.

Chapter Three reviews the literature and critically discusses the possibility of integrating traditional healing and Western healing. The emphasis is placed on the strengths and weaknesses of traditional healing and how they would impact on the proposed integration.

Chapter Four, under the umbrella of 'methodology', covers (amongst other issues) the research design, instruments for data collection, the procedure followed when collecting data and the statement of ethics relating to doing research with humans.

Chapter Five presents the results of the statistical analyses of questionnaires and the results derived from qualitative statements in the questionnaires.

Chapter Six, the final chapter, discusses the results as well as the practical implications of the findings. Methodological limitations of the present study and

recommendations for further research in the area of traditional healing are highlighted in this chapter which concludes by summarising critical points covered in the current study.

1.8 CONCLUSION

Research in any area of interest is like a relay race in athletics minus the aspect of competition and the finish line. Learning in any area will never stop. Like participants in a relay, researchers pick up from where others before them have left off. They aim to describe, understand, explain and solve problems. These are the basic tenets of applied research. Some problems are huge and formidable and need multiple strategies if they are to be solved. In South Africa, the health care sector, in general, is one of those problems. The proposed integration of traditional African healing and the Western-inclined healing is only the tip of that 'iceberg'.

The World Health Organization declared the intention that there should be better health for all by the year 2000 (Gumede, 1990a). In 2012, this ideal is far from being realised. Rudnick (2002, p.7) took the relay baton from others and looked at the links between Western psychotherapy and traditional healing and hoped that his thesis, to use his words, "*will not follow countless others and die a dusty and lonely death on an untidy shelf in an obscure library*". The present study looked at health care practitioners' opinions of, attitudes towards, knowledge of and experiences with traditional African healing and their implications for integration of the two worldviews. It hoped to make a contribution in the never-ending relay of knowledge creation and subsequently knowledge application. Other researchers will pick up from where this project leaves off; and, it is hoped, some in decision-making positions in the health care and government sectors will find it useful.

To familiarise the reader with traditional African healing and with Western medicine, the next chapter juxtaposes the two healing systems. It ends by looking at commonalities and differences between the two systems.

CHAPTER TWO

JUXTAPOSING TRADITIONAL AFRICAN HEALING AND WESTERN HEALING

2.1. INTRODUCTION

Rapid increases in the costs of modernised health care are forcing poor and underdeveloped/developing countries to look for other approaches to primary health care (Bodeker, 1995; Stanton & Rutherford, 2002). Traditional medicine is usually the first, and often the last, resort for health care of the poor throughout the developing world (Bodeker, 1996; Van Niekerk, 2012). Many poor people's health care needs would be adversely affected if the traditional health care systems were to be taken out of the equation particularly in a country like South Africa with its severe unemployment problem.

Relative to other African countries, South Africa is a young democracy. Having been liberated from minority Nationalist Party rule in 1994, many areas of activity are still divided between Western and African philosophies. To encapsulate these divisions, one needs only listen to the discussions and debates about religion, traditional healing, '*lobola/magadi'* and traditional ceremonies on talk radio stations, in the newspapers and other public forums throughout the country. One would immediately realise that South Africa is a complex country to try to synergise in any way. One of the challenges seems to do with people's opinions of, attitudes towards, knowledge of and experiences with others' ways of life.

The colonial authorities and subsequently the apartheid government imposed a Western worldview on the people of South Africa without an attempt to determine the validity of the African worldview on issues such as traditional African healing and traditional African religion/spirituality. The Western worldview was imposed through the implementation of an inferior Bantu education that sought, amongst other things, to teach black people to despise their own cultural practices and traditional systems (Christie & Collins, 1982). Traditional healing and religion/spirituality are mentioned here because, as well as the fact that traditional healing is the subject of the current study, the two are in most cases mutually interwoven. This idea was well captured by Gumede (1990a) and by Nelms and Gorski (2006) who asserted that it would be difficult to understand the traditional healer

and his/her trade without taking the concept of traditional African religion/spirituality into account. Chavunduka (n.d.) gave two main reasons why it is difficult to separate traditional African healing from traditional African religion or spirituality:

(1) The traditional African philosophy of illness in most cases encompasses relations between God, ancestors and the universe; and

(2) Many traditional healers double as religious leaders (priests and prophets) in African independent churches and vice versa.

Given the above assertion, this chapter discusses the following issues, amongst others:

- Traditional African religion/spirituality
- African cosmology and traditional beliefs
- Thanksgiving and fortification of life and property
- Traditional African healing and traditional medicine
- Different types of traditional healers and how traditional healers are trained
- The number of traditional healers in South Africa
- The role of traditional healers in their communities
- The conceptualisation of illness in traditional and Western healing
- Convergence and divergence between the Western and traditional healing models

At the end of the chapter, the traditional African and Western worldviews are compared and contrasted. The focus of this chapter is therefore on what traditional healing and Western healing are about as well as on differences between the two health care systems regarding their conceptualisation of illness.

2.2 UNDERSTANDING TRADITIONAL AFRICAN HEALING

To better understand traditional African healing, one needs to take traditional African religion/spirituality into account. The two cannot be separated.

2.2.1 Traditional African religion /spirituality

Religion is not an easy concept to define (Laher, 2007). The etymology of its Latin original remains a subject of contestation (Nigosian, 1994). Religion means different things for different people (Smart, 1992). Nigosian (1994, p.4) defined religion in general as " *an invention or creation of the human mind for regulating all human activity, and this creative activity is a human necessity that satisfies the spiritual desires and needs inherent in human nature*". The traditional African religion, in particular, can be described as tribal (Van der Walt, 2003). In other words, its practice varies from tribe to tribe but the substance remains the same all over Africa. A tribe is defined by the Concise Oxford English Dictionary as a *social division in a traditional society consisting of families or communities linked by social, religious, or blood ties, with a common culture and dialect, typically having a recognised leader"* (Pearsall, 2001, p.1530).

Traditional African religion had existed for many centuries before the arrival of Western Christian missionaries and Western political expeditions on the African continent. With the scramble for and the Westernisation of the African continent in the 19th century, many Africans became Christians not by choice but by force. Nonetheless, it is also worth mentioning that others became Christians by choice. In many parts of apartheid South Africa, an African child had to have a 'Christian' name before she or he could be enrolled at a primary school. This is where many African children were introduced and 'converted' to the Christian religion. Contrary to the intentions of colonial authorities and the apartheid government, this forced conversion and Westernisation did not lead to Africans completely abandoning the traditional African health care system and African religion (Chavunduka, n.d.; Imperato, 1981; Nigosian, 1994). Instead, many Africans utilised the services of both the traditional and Western health care systems and practiced Western and traditional African religions concurrently.

Before the Westernisation process, Africans had always believed in God and the ancestors and had been profoundly spiritual. This is contrary to some colonial authorities and Christian missionaries' general beliefs that Africans were un-believers. Africans believed and continue to believe in the eternal and ubiquitous spirit of the ancestors and the Almighty God. The ancestors are called by different names depending on one's ethnic origins. The Bapedi, Batswana, and Basotho call them '*badimo*'. The Amazulu and the Amaxhosa call them '*amadlozi'* and *'iinyanya'* respectively.

The ancestors are the 'living-dead', compassionate spirits who are blood-related to the people who believe in them. The ancestors continue to show an interest in the daily lives of the relatives that are still alive (Berg, 2003; Chidester, 1992; Fisher, 1998; Van Dyk, 2001). They are superior to the living (Ejizu, n.d.). They include, amongst others, departed/deceased parents, grand-parents, great-grand-parents, aunts and uncles. These spirits, because they have crossed over to the other side of life, act as mediators between the living and God. This way of life is regarded as ancestor reverence, veneration or remembering and not as ancestor worship (Berg, 2003; Buhrmann, 1984; Fisher, 1998). The word 'worship', when referring to communication between Africans and the ancestors, is therefore inappropriate since the ancestors are not worshipped but remembered and revered by their relatives (Child & Child, 1993). In traditional African religion, God is above and beyond the ancestors and is called the Supreme Creator/Being and the main pillar of the universe (Moyo, 1987; Smart, 1992; Thorpe, 1993). This is one aspect that many people who do not subscribe to this belief system fail to understand: that the God that the traditional African religion subscribers worship is the same God that Christians and other religious groupings believe in. Because African religion reveres and holds God in the highest regard, worshipers do not speak directly to Him. Their prayers and wishes are communicated to Him through the medium of the ancestors. This is often aided by enlisting the services of a traditional healer who advises on how to communicate with the ancestors, depending on the purposes of the communication and the type of ritual that needs to be performed.

Traditional African religion, therefore, involves a chain of communication between the worshipers and Almighty God. This chain is, as would be expected, influenced by the cultural context in which it exists, just as Christianity and other religions are embedded within their particular cultural milieus. Christians communicate directly with God, or through Jesus Christ, whilst traditional African religious believers communicate with God through the

medium of the deceased relatives. The deceased relatives are ‘means-to-an-end’ and not the end in themselves. They are conduits of their relatives’ prayers to the Almighty.

At times, communication between the living, the living-dead and God is done through the ritual slaughtering of an animal (Gumede, 1990a). The practice of ritual slaughtering in traditional African religion is akin to the animal offerings carried out by people in the Old Testament of the Bible. It can be argued that the main difference is that people in the Old Testament were making animal sacrifices directly to God whilst traditional African religious believers make animal sacrifices to God through their departed relatives who have attained the status of being ancestors and therefore mediators between their living relatives and God.

Different types of animals can be slaughtered for the purposes of communication between the living, the ancestors and God. These include chickens, goats and cattle, depending on the instructions or preferences of the ancestors. The slaughtering of an animal has to be done properly and at an appropriate place. For example, such sacrifices could not be made at the modern abattoirs. They must be made at the homestead of the person/s concerned so that blood can be spilled there. Blood is an extremely important aspect in the traditional African religion and customs. It serves as a bond between the ancestors and their descendants. This is one of the reasons why an animal has to be slaughtered when two people get married, for example. The blood of the slaughtered animal is believed to be the eternal bond between the families and the ancestors of the two families that are coming together through the bride and bridegroom.

Gumede (1990a) mentioned three basic tenets of a properly made sacrifice. These are that:

- There must be an appropriate animal, such as a cow or bull of a particular colour depending on the occasion.
- There must be home-brewed beer that will go with the sacrifice. It is widely believed that the ancestors particularly prefer a home-brewed sorghum beer.
- There must also be frankincense which is often provided for by the traditional healer.

For communication to be heard by the ancestors, great care has to be taken when making such sacrifices. That is why one needs to consult with those who know the rituals, such as

traditional healers. They are thought to receive spiritual guidance from the ancestors on how to make the sacrifices properly.

Sacrifices and ancestor reverence are not confined to the ancestors at the personal and family levels only. These kinds of sacrifices can also be made, during an extended period of famine that threatens the life of humans, animals and plants, to what are normally called 'the village ancestors': the spirits of departed chiefs and other high ranking royal figures. In the Bapedi tribe, the majority of whom are found in the Limpopo province north of South Africa and particularly in the former Lebowa homeland, this is achieved by gathering all of the village girls who are still virgins and have not, as yet, gone through the rights of passage into womanhood or adulthood. They gather at the chief's homestead or compound and are then taken to the village river by women elders to draw water using containers made of clay, called '*meetana*' ('*moetana'* – singular) (Chidester, Kwenda, Petty, Tobler & Wratten, 1997; Harries, 1929). This water is carefully mixed with rain-medicine to sprinkle the earth with (Hammond-Tooke, 1974). This is done with the proper guidance of the chief traditional healer for that particular village called '*Ngaka ya Moshate'* in Sepedi. Providing he is a rainmaker, this could be the same traditional healer who fortifies both boys and girls during the initiation period when they come of age. It is believed that the rain will come down as soon as the girls arrive back from the river having performed the necessary rituals both at the river and at the place where the departed chiefs are buried. It must be emphasised that these rituals cannot be performed without the rainmaker's instructions and the spiritual guidance of the ancestors.

If it happens that these rain rituals do not yield satisfactory results, another ritual is performed. This entails village men hunting a type of buck with short horns, called *'Kome'*. It is normally found in the mountains and this makes it difficult to catch. The buck must be caught alive and brought to the rainmaker who mixes some of the fur of the buck with rain-medicine and call upon the ancestors to shower the village and its environs with rain (Eiselen & Schapera, 1962).

The spirit of the ancestors is invoked in many other instances. For example, one's ancestors have to be informed when one gets married. The groom and bride are each taken to the graves of their ancestors by their respective parents or elders in the family. The parent or elders talk to the ancestors on behalf of those who are getting married. This usually happens a

day before the slaughtering of animals can begin. It is believed that if the couple does not follow this spiritual protocol, a series of malevolence will befall them in their marriage.

Another occasion where the approval of the ancestors is sought is when the married couple decides to establish their own homestead. This is called '*go tjea lefata'* in Sepedi. The ancestors are informed about where the homestead is to be built and their spirits are asked to always protect the homestead and its inhabitants from harm and misfortune (Silva & Loforte, 1998). If it happens that after the homestead has been established and the ancestors are not happy with its location, the ancestors can give instructions that it be moved to a place of their choosing.

The instructions to move the homestead are communicated by sending spiritual messages through to their descendants. There are several channels that the ancestors utilise to bring the message to the one it is intended for. In the above example, the ancestral spirits can go directly to the one concerned or they can use other blood-relatives as conduits for their messages. This can be done through recurrent dreams, visions and even mishaps and calamities. Traditional healers can verify and validate these messages or instructions through the use of bones, called '*dipheko or ditaola'* in Sepedi.

2.2.2 African cosmology and traditional beliefs

Apart from dreams and visions, traditional African religion involves different and specific interpretations of the movement of extraterrestrial bodies such as the sun, moon and stars and elements like winds, lightening and water. Water in the form of waterfalls is believed to have healing powers. This view is particularly held by prophets and priests in the African independent Christian churches such as the Zion Christian Church (ZCC) and Apostolic churches (*'Mapasetolo'*). People can walk for many kilometers in search of waterfalls or springs when given an instruction ('*taelo'*) to do so by prophets and '*mabone*' in some African independent Christian churches (Anderson, n.d.).

There are certain premonitions related to the celestial bodies that Africans observe very carefully. For instance, in the *Bapedi* cosmology, a large shooting star is believed to signal the death of a chief or eminent member of the royal house ('*moshate'*) within the village or the surrounding villages. The moon appearing red may signal danger, although it is

not necessarily clear what sort of danger this may be. Storms, whirlwinds, strong winds and particularly tornadoes and typhoons that cause destruction along their path are believed to be caused by the mermaid ('*mamokebe*') as it moves from one area to another, destroying things in its path. These phenomena can also be attributed to witchcraft, in which case the services of traditional healers, and particularly the diviners (to be discussed below) are enlisted to determine who has caused the destruction and why (Child & Child, 1993). For example, recently a Xhosa prince's wedding to his second wife was interrupted by strong winds and rain that destroyed the four marquees in which the wedding reception was held. Some of the visitors appeared to have suggested that the prince's first wife was involved in the destruction of the marquees because of jealousy (George, 2008). One can understand how such beliefs can cause rifts and conflicts between families.

Lightning is also believed to be the work of witches, a certain bird that is capable of producing lightening or the ancestors trying to discipline someone who is not living up to the ancestors' expectations of established decorum (Gumede, 1990a; Harries, 1929). If witches are found to be the cause, the traditional healer can retaliate on behalf of the one who suffered as a result of the lightening strike. This is called '*go beya letjwa'* in Sepedi, and reflects the same or a similar evil act back to the perpetrator/sorcerer. However, if the ancestors are responsible for the lightening, they need to be pacified. One way of pacifying them is through slaughtering of an animal and performing specific rituals.

2.2.3 Thanksgiving and fortification of life and property

Slaughtering of animals as offerings to the ancestors also occurs when an individual or his or her family want to give thanks to the ancestors for a prosperous year and also for the continuous protection/fortification of the family or newly acquired assets. For instance, when one buys a new car, one ought to kneel down in front of the graves of their ancestors and inform them about the newly acquired property and ask that they should keep a protective eye on it. It is believed that the car may be vulnerable to the evil work of the witches if one does not observe the custom of asking the ancestors for their protection. In addition to the blessings and fortification by the ancestors, traditional healers' medicine is used to reinforce the power of the ancestors (Gumede, 1990a).

2.2.4 Traditional African healing and traditional medicine

Defining traditional healing is not easy, and there can be many definitions of it. The World Health Organization (WHO, 1976, p8) defined traditional medicine as:

> "*the sum total of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing"*

The present study adopts the above definition as well as a more comprehensive version of it, The WHO (2003, p1) further defined traditional healing/medicine as:

> " *health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain well-being"*.

Traditional healing stretches from treating illnesses with herbs to spiritual treatment (UNAIDS, 2006*).* It is holistic in its approach and embodies the collective wisdom of indigenous knowledge handed down over many generations (Ashforth, 2005).

Although researchers use the umbrella term 'traditional healing' when referring to many healing systems different from the Western (modern) healing system, traditional medicines across the world are dynamic and variable because of the different regions and countries of origin and because of the different agricultural systems in which they exist (Good, Hunter, Katz & Katz, 1979). Traditional healing is not a homogenous healing system, but varies from culture to culture and from region to region. It seems to be well rooted in some countries and regions as compared to others (Sofowora, 1996): for example, it is well organised and established in countries such as China compared to countries such as South Africa.

Craffert (1997) argued that illness and health care systems in any society (whether traditional or Western) are in one way or another determined by or closely connected to the culture or world-views of those societies. Every society develops its own cultural way of dealing with illnesses. For example, the Chinese, native Americans, native Hawaiians, Australian Aborigines, Indians, Maori in New Zealand, indigenous Africans and many other

indigenous peoples have their own special ways and remedies for dealing with physiological, psychiatric and spiritual conditions. To use Carl Jung's concept, these could be regarded as part of the 'Collective Unconscious' of these societies (Berg, 2003). Aspects of this collective unconscious tend to resurface in some few select individuals in the form of traditional healers.

George Kelly, an American personality psychologist and philosopher, developed the philosophy that he called 'Constructive Alternativism', which challenges the notion of a single objective reality (Boeree, n.d.; Pervin & John, 2001). Although reality exists, it can be constructed, interpreted and understood in different ways. What we see as objective reality is the result of our own limited and perhaps biased interpretation of phenomena that we as humans may never fully know and understand. For example, the traditional African healer has a different construction and etiology about schizophrenia (*mafofonyane)* to that of a Western healer. The Western healer may primarily look at the biological (chemical) basis of schizophrenia, while the traditional African healer might look at witchcraft and ancestors as possible causes. The question arises as to when one tells that one construction is better than another, especially if the two constructions of reality seem to be very different, as is the case with schizophrenia.

In fact, the etiology of schizophrenia is still a matter of debate even in the bio-psychosocial literature, with many authors opting for a multifaceted approach (Beck, 1986; Luhrmann, 2012). This suggests that schizophrenia may be caused by a variety of factors ranging from biological to environmental stimuli. Boeree (n.d.) maintained that no one's construction of any phenomenon, including schizophrenia, is ever complete because the world is too large and complicated for anyone to claim to have the perfect perspective which could be regarded as universal. Thus, "*almost everything, even science, turns out to be a matter of opinion, simply because it is so hard to prove or know anything beyond doubt or question*" (Rudinow & Barry, 2004, p.15). Therefore, what needs to be emphasised in the case of ill health is the whole issue of 'cultural relativism' which suggests that experiences and interpretations of illness or misfortune are culture-dependent (Teuton, Bentall & Dowrick, 2007). Effectively, the differences in the interpretation of illnesses and misfortunes are qualitative in nature.

Rudnick (2002) stated that the South African worldview in this regard is just as highly complex and heterogeneous, and can appropriately be divided into two broad categories,

namely (a) the Western and medical, and (b) the African and spiritual categories. The African and spiritual category has been in existence for many centuries. Traditional healers in South Africa have been practicing their trade by using what Hess (1998) called the fruits of the earth gathered in the mountainous areas of the country. This notion was well argued by Barsh (1997) who maintained that traditional healing systems do not simply fight diseases with drugs but take into account the fact that patients are different and come from different cultural and traditional backgrounds, and therefore apply different treatments to their conditions. In other words, traditional healers do not apply the 'one size fits all' approach to their clients. Each treatment is tailor-made to agree with each patient's cultural beliefs and practices.

There are different types of traditional healers in South Africa and elsewhere on the African continent. In the same way as it is not entirely clear how many types of traditional healers the country has, different authors disagree on certain categories; and debates and discussions about categorizing traditional healers are ongoing at the legislative and the academic literature level (Anokbonggo, Odoi-Adome & Oluju, 1990; Freeman & Motsei, 1992; Government Gazette, 2005; Green & Makhubu, 1984; Rudnick, 2002). For the purposes of clarity, however, an attempt is made here to categorise traditional healers.

2.2.5 Types of traditional healers

Traditional healers, like medical doctors, are not a homogenous group (Ensink & Robertson, 1999). The term 'traditional healer' is an umbrella concept that encompasses different types of healers with different types of training and expertise. More detail is provided on this below. In South Africa, much literature on traditional healing uses the Nguni (i.e. isiZulu, isiXhosa, isiSwazi and isiNdebele) terminologies (Freeman & Motsei, 1992; Green, 1985; Gumede, 1990a; Rudnick, 2002; Upvall, 1992; Varga & Veale, 1997; Yen & Wilbraham, 2003). This thesis predominantly uses Sesotho (an umbrella name for Setswana, Sepedi and Sesotho) terminologies, in addition to Nguni terminologies. This is for convenience, as the author comes from the Sesotho cultural background and is familiar and comfortable with Sesotho terminologies.

Researchers have identified different types of traditional healers in different regions (Freeman & Motsei, 1992; Green & Makhubu, 1984). In the Bapedi tribe, traditional healers

are generally called '*dingaka'* or *'mangaka'*. The following terms describe each type of traditional healer.

2.2.5.1 Diviner ('*Ngaka ya ditaola'*)

The diviner uses bones and the spirits of the ancestors to diagnose and prescribe medication for different physiological, psychiatric and spiritual conditions. This category includes those that deal with '*mafofonyane'* (schizophrenia) and '*malopo'* (being possessed by the spirits of the ancestors that can be healed without the possessed person becoming a traditional healer him or herself). *'Malopo'* can be treated by a combination of therapies that include dance (Hammond-Tooke, 1989).

2.2.5.2 Sanusi ('*Sedupe'*)

A Sanusi can manifest in a variety of forms: as a combination of diviner and herbalist, or as is the case in the African independent Christian churches, in the form of a prophet or what the Zion Christian Church calls *'lebone'*. This is someone who is possessed by the Holy Spirit and is able to tell people what will happen in the future and what they need to do to avert that if what will happen is considered undesirable. The '*mabone*' (singular: *lebone*) are the equivalent of '*baporofeta* ' (prophets) in other African independent churches.

For healing purposes, some of the prophets, as is the case with the prophets in the Aladura church in Nigeria, use water in addition to prayers (Rinne, 2001). They often combine the Christian Holy Spirit with the ancestral spirit which falls within the realm of traditional healing (Hammond-Tooke, 1989; Truter, 2007). They thus often assume several roles of the diviners (Thwala, Pillay & Sargent, 2000). According to Green and Makhubu (1984), the *'baporofeta'* emerged out of independent churches that sought to Africanise Christianity by including African traditions and customs in their religious practice. In that they all encourage faith healing, the independent churches have a religious philosophical link with the Christian Catholic Church in Zion and the Apostolic Faith Mission (Peltzer, 1999; Randi, 1987).

The '*baporofeta*' and the 'Africanness' of the independent churches are some of the major aspects that attract millions of Africans to these churches; hence, the Zion churches are the largest in South Africa (Anderson, n.d.). It is, however, noteworthy that Green and Makhubu (1984) do not regard the '*baporofeta*' category as traditional healers although they concede that they share a common theory of health and disease with traditional healers. The basic difference between faith healers and traditional healers, Green and Makhubu argued, is that the former receive guidance from God and the Angels while the latter are guided by the ancestral spirits. What is confusing about their argument is that some of the former use herbs at times; how this is connected to God and Angels is not entirely clear. It does not appear that Green and Makhubu believe that traditional healers also receive guidance from God.

Contrary to Green and Makhubu's (1984) assertion that '*baporofeta*' are not traditional healers, the present study categorises them as traditional healers. This categorisation is in line with the Traditional Health Practitioners Act of South Africa which classifies the '*baporofeta*' in this way (Government Gazette, 2005). In some instances, the line that divides types of traditional healers can be very blurred, as one type of traditional healer can incorporate the other (such as a diviner practicing as a herbalist).

2.2.5.3 Traditional surgeon

Traditional surgeons include those who are qualified, accredited, trusted and recognised by village chiefs to perform circumcision on boys (Government Gazette, 2005). Their practice and expertise as surgeons can also encompass the practices and expertise of other types of traditional healers such as diviner and *sedupe/sanusi*. In other words, some traditional surgeons also operate as diviners and *sanusis*.

2.2.5.4 Traditional birth attendant ('*Mmelegisi'*)

Traditional birth attendants are usually older women who have perfected the skill of midwifery over the years through experiencing, witnessing and assisting in many births throughout their adult lives. The skill is transferred from one generation to the other. As a result, any older woman can become a birth attendant. It remains to be seen if the traditional

birth attendant category will survive for long, as more and more people prefer to give birth in hospitals and not at home as it was previously the case.

2.2.6 Number of traditional healers in South Africa

It is difficult to establish the exact number of traditional healers practicing in South Africa. There are many unregistered South African traditional healers, both in urban and rural areas. To further complicate this issue of registration or lack thereof, there are many foreign nationals that practice as traditional healers in South Africa without proper registration. Nonetheless, Gqaleni, Moodley, Kruger, Ntuli and McLeod (2007) estimated that there are approximately over eighteen thousand registered traditional healers in South Africa and most of them are found in Gauteng province, the economic hub of this country. The training of traditional healers is currently not regulated and this is considered problematic because there is no way of verifying the quality of training that trainee traditional healers undergo.

2.2.7 Training of traditional healers

For certain categories of traditional African healers such as diviners, training is a formal and meticulous process that can take between months and years depending on how fast the trainee (‘*lethasana’*) learns the trade (Peek, 1991). Not everybody can become a traditional healer just by choice alone, and traditional healing is regarded as a special calling from the ancestors. This calling can come through what is generally called illness in the Western paradigm. These include schizophrenia and psychosis, as well as constant visitations through dreams by one’s ancestors who want one to become a traditional healer. The visitations can also be in the form of apparitions. The authenticity of such callings must be verified by a diviner who advises on which trainer to go to for training. It is vital that a prospective trainee goes to an appropriate trainer.

Moreover, not every qualified traditional healer is qualified to train prospective traditional healers. Training of traditional healers is a specialty and yet another calling, in addition to simply being a healer. A traditional healer has to be called to become a trainer of other future healers. There are traditional healers who combine both the normal traditional healing and who specialise in training of prospective traditional healers.

During training, the trainee is required to live with his or her trainer, the trainer's family and other trainees, and is therefore constantly observed by the trainer (Buhrmann, 1984; Rudnick, 2002). All trainees become part of a single large family and their training academy becomes home away from home. In some cases, the trainee will only be allowed to go home once the training has been completed, although the relatives of the trainees are allowed to visit them during their stay at the academy. During the training process, trainees learn a variety of things such as different medicinal plants and animal extracts to use, interpreting the bones, dream analysis, communicating with the ancestors and different illnesses and how to treat them.

There are certain practices that are proscribed during the training process. These are all instructions from the ancestors. For example, a trainee does not greet other people by shaking hands. When greeting others, especially when they meet others in the homestead, they kneel down and clap hands by placing one hand over another in an up and down fashion or sideways. When they meet relatives outside of the homestead, they drop a curtsy and clap hands without kneeling down. Normally, they would not greet strangers outside the homestead. A trainee does not engage in a sexual relationship with anyone else. This is called '*go ikilela'*: total abstinence from sexual intercourse. It is a common belief that if one has sexual intercourse or engages in any proscribed practices during training the ancestors will not assist that person to learn the art of traditional healing (Hammond-Tooke, 1989).

Once the training is finished and the trainer is satisfied with the progress that the trainee has made, the trainee is taken to a river where final rituals are performed. There is then a ceremony in the presence of community members, called '*go ja ntwase'.* Animals are slaughtered according to the instructions of the ancestors that are communicated to the trainer through the trainer's divination. This ceremony is a form of an assessment to test if the trainee has learned the trade and can be allowed to graduate and therefore practice as a traditional healer (Mutwa, 2003).

One of the methods that the trainer healer employs when assessing the trainee's level of competence in using the spirits of the ancestors is to hide a safety pin in the vicinity or in one of the spectators' pockets. This is done in the absence of the trainee. The trainee must be guided by the spirit of the ancestors to find the pin within a short period. The trainee will start singing and dancing at the beating of the drums, and the community members who came to witness the ceremony sing along and clap their hands in unison (Peek, 1991). Eventually, the

trainee is in a state of abstraction and he or she goes straight to where the safety pin has been hidden and pulls it out. If it happens that the trainee fails this assessment, the training may be extended by some more months. That may involve some extra costs in terms of payment for the training.

Traditional healer training can be very expensive. Payment can either be in cash or in the form of cattle, sheep, etc. depending on the trainer's preferences and the economic conditions of the trainee's family (Campbell, 1997). This, therefore, becomes a negotiated settlement. Once the training is complete, the graduate is allowed to practice as a traditional healer. Often the success of the newly qualified traditional healer depends not only on his or her competence in diagnostics and treatment of illnesses but also on where he or she has received training and thus the popularity and seniority of the trainer; this is not dissimilar to the rankings of university departments, schools and faculties. Upon graduation, a traditional healer is certified by his or her trainer as being ready to fulfill his or her role in the community.

2.2.8 The role of traditional healers in their communities

In all African regions, traditional healers are very resourceful and play a pivotal role in many spheres of the people's lives. Their role cannot be emphasised enough. In addition to being a 'medical knowledge storehouse' (Yeboah, 2000), African traditional healers serve important roles as educators about traditional culture, cosmology and spirituality. They also serve as counselors, social workers and skilled psychotherapists as well as custodians of indigenous knowledge systems (Berg, 2003; Mills, Cooper & Kanfer, 2005).

The services of traditional healers go far beyond the uses of herbs for physical illnesses. They have, for example, been found to be invaluable in post civil war social reconstruction and community rebuilding in Mozambique, particularly in the rural areas (Honwana, 1997). It is doubtful whether modern psychological and psychiatric services would have been appropriate in Mozambique, since traditional healing was highly involved by rendering culturally relevant psychological services that included communication with the ancestors (Honwana, 1997). This raises the important question of how illnesses/conditions are conceptualised in each of the two healing models.

2.3 CONCEPTUALISATION OF ILLNESS IN TRADITIONAL HEALING AND WESTERN HEALING

The traditional African healing system conceptualises some illnesses differently from the Western healing system. The following sub-sections discuss how each model deals with the etiology and conceptualisation of illness. Much emphasis is placed on traditional healing as this system often goes beyond the scientific 'germ' theory in its conceptualisation of illness. Conceptualisation of illness outside the realm of the scientific 'germ' theory is complex and difficult to understand, hence much spotlight in the current study is on traditional healing.

2.3.1 Conceptualisation of illness in the traditional African healing model

The traditional African healing model finds it difficult to subscribe to what Gumede (1990a) called 'the germ theory' of Western medicine. The African psyche is relatively unique with regard the origins of some physiological, psychiatric or spiritual illnesses. Writing about the conceptualisation of illness among the African patients, Gumede (1990a) mentioned that Africans generally believe that disease is either a man-made phenomenon (witchcraft and sorcery) or it results from a communiqué from the ancestors.

2.3.1.1 Witchcraft and ancestral spirits as causes of illness

A man-made disease is thought to be caused by witchcraft or sorcery (Courtright, Chirambo, Lewallen, Chana & Kanjaloti, 2000). There is a clear semantic difference between the concepts of witchcraft and sorcery in the English language. Witchcraft is defined as a belief in a supernatural power possessed by certain individuals and utilised by those particular individuals to cause harm to their adversaries (Wilson, 1951). This is different from sorcery, which is the malevolent use of medicines to cause harm on others. It is important to understand, however, that the two are often combined in practice. In the African languages such as Sepedi, Setswana and Sesotho, only one word is used to describe both the concepts of witchcraft and sorcery, namely '*boloi*'.

Beliefs about witchcraft are prevalent in African communities (Ivey & Myers, 2008a; Mair, 1972). In fact, it is doubtful if there is any African society that does not believe in

witchcraft (Evans-Pritchard, 1935). As cultures and traditions evolve, there are of course exceptions to the general belief in witchcraft. Some individuals in these societies may not believe in witchcraft, although they will tend to in the minority. Beliefs in the existence of witchcraft are even pervasive in the African Christian Charismatic Movement (Akrong, 2000). This is ironic because the charismatic churches are perceived to frown upon African culture and traditions. However, these churches thrive in African communities, on the claim to better heal witchcraft-related illness, some opting to use mass media such as television to showcase their effectiveness of dealing with witchcraft and subsequently attracting very large numbers of Africans to the churches.

In African communities, beliefs in the existence of witchcraft can lead to believers taking the law into their own hands. Many witchcraft-related criminal cases are rooted in but are not limited to largely rural South African provinces such as Limpopo, Mpumalanga and the Eastern Cape (Petrus, 2009). Because beliefs about witchcraft are deeply entrenched in African communities, it is virtually impossible to eradicate them (Ciekawy & Geschiere, 1998). Witchcraft is seen as a form of weaponry when one wants to harm one's enemy or even as an expression of jealousy over the enemy's successes (Haram, 1991). Ironically and in many instances, these enemies are relatives, neighbours and even friends of the person accused of being a witch (Ashforth, 1998).

It is believed that witches use animals and birds like owls, bats, snakes, baboons, cats and hyenas as mode of transportation to move swiftly from place to place and to bewitch their victims during the night (Child & Child, 1993; Hammond-Tooke, 1989). Animals are not the only mode of transport thought to be used by witches. Others include inanimate objects such as brooms, loafs of bread and bath tubs. Witches are even thought to use their magical powers to bewitch their adversaries without coming into physical contact with them (Ashforth, 2005). It is not clear how they perform these metaphysical acts; this is believed to be a well kept secret amongst the initiated, with witches being sworn to secrecy. One has to join them to learn about their operations. But how does one join the witches if they are not willing to identify themselves publicly? Posing this question to any believer in witchcraft will not produce a satisfactory response. It might be thought that modern science with its technological advancement would assist; however, there is no scientific instrument to verify the existence or nonexistence of witchcraft, which therefore remains a mystery and beyond science. It is thus metaphysical.

The deeply rooted beliefs about the existence of witchcraft in African communities have far reaching practical implications. People who are suspected of practicing witchcraft have been subjected to many forms of humiliations. Sporadic insurgence against witches and witchcraft are occasionally witnessed in Limpopo province, with so-called witches being hunted down and 'flushed out' of their villages; in extreme cases, their homesteads have been burnt down and so-called witches killed by members of the community.

In some cases, '*boloi*' (witchcraft) can be likened to an irrational fear. For example, in African communities, car accidents are often attributed to the work of '*baloi'* (witches/sorcerers; *'baloi'* is a plural form of '*moloi*'), and there is the potential for danger when relatives of the casualty publicise the name of the person allegedly responsible for the accident or accuse them of inflicting an illness on their relative. Often, a diviner does not directly mention the name of the person who has allegedly bewitched another, only giving a description of that particular witch. The diviner may simply say that the one who is bewitching you is an old woman, not tall, dark in complexion and living not far from you (the victim); or that the perpetrator is a relative from the father's or mother's side. Such descriptions are vague and potentially dangerous, as it is left up to the 'bewitched' to determine who may be responsible for their maladies. In most cases, the least liked relatives or neighbours are indentified as the perpetrators (Ivey & Myers, 2008b). It is also common that old ladies perceived to be less attractive are accused of being witches. Perhaps researchers should investigate this phenomenon more. However, not all illnesses and misfortunes are attributed to witches in traditional African healing.

According to Hoff and Shapiro (1986), traditional healers classify illnesses not only as man-made or African (e.g., '*mafofonyane'*) but also as modern (those that come naturally and are not inflicted by '*baloi*', e.g. influenza). The latter view is similar to the Western worldview, as it incorporates the germ theory. Therefore the traditional African worldview regarding the origins of illnesses is not one-sided, although it tends to lean more towards witchcraft or sorcery as the cause. Another cause of illness is thought to be the wrath of ancestors, especially when one is not performing the relevant and necessary rituals as required by custom and expected by the ancestors (Crawford & Lipsedge, 2004).

As can be seen above, "a *broad range of factors such as organic evidence, subjective perceptions, and mental, emotional, social, and spiritual conditions, are considered relevant to the observation and classification of illness in traditional healing*" (Bastien, 1987, cited in

Alderete, 1996, p.379). Good et al. (1979) pointed out that the diagnosis of illnesses in traditional medicine is largely based on the healer's observing aspects of the patient's behavior, divination, clinical examination, etc., with diagnosis normally being in accordance with the patient's cultural milieu. Illness is conceptualised as a result of the interaction between the spiritual and the material realms which are inextricably linked; and healing means being healed physically, socially, psychologically and spiritually (Alderete, 1996; Kwenda, Mndende & Stonier, 1997). In other words, wellness relies on the holistic combination of mind, body, spirit and community or extended family (Pesek, Helton & Nair, 2006). Van Dyk (2008) referred to this type of approach as the holism of the traditional healing outlook.

In summary, illness in traditional African communities and in the traditional African healing model is largely thought to be caused by witchcraft and ancestors' anger. The breaking of taboos, and pollution, are also blamed for a variety of illnesses in traditional African communities (Foster, 1976; Ingstad, 1990).

2.3.1.2 Breaking of taboos and states of pollution as contributors to ill-health and other undesirables

Taboos in traditional African communities are aimed at encouraging and maintaining the state of cleanliness as well as respect for the environment and humans. Taboos vary from community to community, but generally it is thought that illnesses are caused when taboos are not properly observed or are totally disregarded (Slikkerveer, 1990). Below are examples of some of the taboos observed by traditional communities in Africa.

It is taboo to leave one's hair pieces lying around after a haircut. One should collect the cut hair and burn it until nothing is left. It is believed that if one's hair is blown away by the wind it may fall into the hands of witches who will use it for evil purposes such as making one mad (Gumede, 1990b). This taboo encourages people to leave their surroundings clean for fear of being bewitched, and is an example of how to take care of the environment.

Babile villagers in Somalia believe that gonorrhea can be caused by looking at the sun while urinating (Slikkerveer, 1990). This is similar to a taboo amongst Zulus that proscribes

them from looking at the stars for a long time (Gumede, 1990b). Both of these taboos are meant to protect people's eyes from potential damage by celestial bodies.

It is taboo for Babile villagers to have sexual relationships outside the house or marriage (Slikkerveer, 1990). This taboo ensures that people do not become sexually promiscuous and, in this age, it may help to lower the incidence of HIV infection, Aids and other sexually transmitted infections. Abortion in the Bapedi tribe is forbidden because it is thought to bring about too much heat in the land (Krige, 1962). This taboo was meant to protect women from unwanted pregnancies and also to protect them from the pain of backstreet abortions.

Some taboos involve human beings and their relationships with birds (Gumede, 1990b). For example, in Bapedi villages it is taboo to kill one type of bird called *'mashianoke or mamashianoke'* (*Scopus umbretta*, commonly known as the hamerkop or 'hammerhead' because of the shape of its head). '*Mashianoke*' builds its nest at river banks, particularly in large trees, and it is believed that killing it or destroying its nest will bring strong and destructive winds to the village. This taboo serves as protection for the species.

The environment is protected from pollution, particularly in the Bapedi tribe called '*Batau ba Mphanama'* in the Sekhukhuneland district in Limpopo province. Once every year before cultivating the land, hundreds of men go around the village and its farms to collect everything regarded as *'sebeela'* (plural: *dibeela'*). '*Dibeela'* are pollutants such as pieces of cloth, plastic and carcasses of animals scattered in the village and its environs. They must be brought together and be burnt in one place. It is believed that *'dibeela'* block the rain from coming down and cause illnesses and must therefore be removed from the village.

On the human side of pollution, women are generally seen as vulnerable and weak (Snow, 1993). Menstruating women, those who have just suffered miscarriage or whose husbands have died and have not been accordingly cleansed are seen as impure. They should therefore avoid sexual intercourse because they might put men at risk of contracting illnesses such as sexually transmitted infections (Hammond-Tooke, 1989). The human side of pollution is problematic because it perpetuates negative sexist stereotypes as the emphasis is more on women as carriers and spreaders of illness. This notion indirectly portrays men as 'victims' of women's impurities. In traditional African communities, it is not uncommon to

hear that a man in the community is sick or has died because he had sex with a widow who had not yet finished her term of mourning the death of her husband.

2.3.1.3 Cultural understanding of specific illnesses

Awareness and acknowledgment of the cultural constructions of illness are important if health care practitioners are to effectively deal with illnesses that their patients present with. Some physical illnesses, such as epilepsy, and some psychiatric conditions, such as schizophrenia, tend to be viewed culturally; such illnesses cannot simply be understood and treated from the strict Western medical point of view (Keikelame & Swartz, 2007). It is therefore important to establish the patient's social and cultural background as well as their own understanding of the conditions that they are presenting with. For example, many people in African communities on the African continent perceive epilepsy as a man-made condition. This perception has led to El Sharkawy, Newton and Hartly (2006) to make a recommendation, specific to epilepsy, in their study of the attitudes and practices of families and health care practitioners towards children with epilepsy in a village in Kenya. They recommended that modern health care practitioners should acquire knowledge of local communities' cultural perceptions about the causes of this disease. People in some communities, in for example Tanzania, understand epilepsy as being caused by witchcraft, sorcery or the breaking of taboos (Winkler, Mayer, Schnaitmann, Ombay, Mathias, Schmutzhard & Jilek-Aall, 2010). For those who think that epilepsy is man-made, when seeking medical attention they would first look for traditional healing. In other communities, such as in Taiwan, traditional Chinese medicine is commonly used for epilepsy (Kuan, Yen, Yiu, Lin, Kwan, Chen, Chou & Yu, 2011).

A knowledge and understanding of local communities' cultural background and perceptions about illnesses can help modern health care practitioners in clarifying the illnesses and can therefore help in the proper treatment and the recovery process of patients (Nzimakwe, 1996). In pluralistic societies, Mulato and Berry (2001) suggested that an understanding of people's cultural background is essential to understanding human behaviour, which includes health and illness. In the view of Mulato and Berry (2001, p.48) "*cultural ignorance is simply bad medicine*".

If Mulato and Berry's (2001) view is valid, it would be correct to say that many African people's recourse, when presenting with any symptomatology especially of a psychiatric nature would be to the traditional African healer, as is the case with epilepsy which is believed to have a supernatural cause and therefore to need treating by traditional healing or spiritual healing (Danesi & Adetunji, 1994). This attests to the fact that many Africans have different perceptions about the causes, treatment and management of such conditions. Africans believe that, although Western healing is effective in treating many illnesses, traditional healing is superior to Western healing in the treatment of psychiatric conditions (Odebiyi, 1990). Thus cultural beliefs about schizophrenia in African communities (that it is man-made in the sense that it is usually inflicted by those who practice witchcraft) may make these communities sceptical about its treatment by Western-trained health care practitioners. In such cases, in place of Western healing, traditional communities tend to prefer traditional African healers as they are believed to understand schizophrenia better than Western-trained healthcare practitioners (Versola-Russo, 2006).

2.3.1.4 Cultural sensitivity in handling patients

Another reason for the popularity of traditional healing throughout Africa appears to be the cultural sensitivity with which patients are handled by traditional healers. It is for example common practice for Western-trained medical practitioners to physically examine the genitalia of patients of the opposite sex when patients are presenting with genital diseases. However, in dealing with diseases of genitalia, traditional healers have a different approach to that of Western medical practitioners (Ndubane & Hojer, 1999). Male traditional African healers have female assistants and female traditional African healers have male assistants who, when necessary, physically examine patients of the opposite sex on their behalf (Ndulo, Faxelid & Krantz, 2001). It is also common practice for traditional African healers to have members of their own nuclear families as assistants in this regard. This practice however lends itself to a violation of the ethical codes of privacy and confidentiality between traditional healer and patient because a third person is involved in the examination process. This may seem similar to the modern doctor having a nurse as an assistant in his or her practice, with the difference being that the nurse is a formally trained health care professional.

To circumvent the problem of confidentiality between traditional healer and patient, some female traditional African healers in South Africa have resorted to utilising model male genitalia to diagnose and discuss sores or other symptoms with male patients (Green, Zokwe & Dupree, 1995). By pointing to a place on the model, patients find it easier to show them where symptoms are located without female traditional healers having 'to violate rules of decorum' by physically examining the patient's genitalia (Green et al., 1995). However, this indirect examination of patients - diagnosing a condition by looking at a model or listening to an assistant's account of the problem - may pose challenges in terms of diagnosis and treatment and increase the likelihood that traditional healers who use such methods may misdiagnose the condition with which the patient is presenting.

Globally, cultural sensitivity in health care practice is crucial. To illustrate this, Lazarus (2006, p.530) reviewed research writings that indicate the importance of *"developing more culturally sensitive and responsive health care systems that integrate different worldviews in a mutually respectful way"*. However, the hegemony of Western healing over traditional healing makes the challenge of developing a more culturally sensitive health care system even more difficult.

2.3.2 Conceptualisation of illness in the Western healing model

Craffert (1997) as well as Fabrega (1990) described the basic tenet of biomedicine/Western healing as likening the human body to a machine in which the parts sometimes do not function optimally, and that disease results from inadequacies and failure of the natural defenses of the body. According to Gumede (1990a), this breakdown of the body makes it vulnerable to an often deadly onslaught of germs in the human body. Gumede (1990a) and Craffert (1997) referred to it as 'the germ theory', whose basic tenet is that there is a causal organism for almost every disease and that the treatment of disease means the repair and/or replacement of parts in the form of drugs and surgery, knowledge of which is monopolised by formally trained medical personnel. This approach (i.e. the germ theory) can at times lead to a failure to properly diagnose and treat conditions such as depression that may have their origins outside the physical body. This may be the case because depression and other similar conditions may have somatic *presentations* and yet the *causes* may not be physiological in nature (Fornaro, Clementi & Fornaro, 2009).

The Western healing model conceptualises illness as being universal. In other words, this healing model is embedded within the 'etic approach' (universalism) in which diagnosis and treatment of illness are considered to be globally applicable (Quinn, 2007). Within this approach, the patient's cultural background is irrelevant when diagnosis and treatment of illness are carried out. This approach at times clashes with the relativist approach of traditional healing in which the patient's culture is taken into account when making a diagnosis and treatment. These stark contrasts in illness conceptualisations can be a source of frustration for a medical doctor who works in traditional communities that do not fully embrace the biomedical model of illness (Poole & Hughes, 2009). Nonetheless, it is worth mentioning that paradoxically, within the Western medical model, some physicians appear to be subtly uncomfortable with psychiatry because they (i.e. physicians) tend to perceive psychiatry as not having an authoritatively pure scientific foundation because of its uncertainties in diagnosing and treating psychiatric conditions (Sartorius et al., 2010). Therefore the 'battle' about conceptualisation of illness does not appear to be solely between Western medical model and traditional healing but the battle also subtly exists within the broader Western medical model itself in which psychiatry is sometimes perceived as inferior (Sartorius et al.).

The Western biomedical model can thus be seen as reductionist and tending to treat the body, mind, and societies as separate entities that are not necessarily linked (Alderete, 1996). The Western healing system traditionally divides illness into the different categories of somatic, psychological and psychosomatic (Buhrmann, 1984). This does not resonate with many traditional societies. In a study that investigated illness and treatment perceptions of Ethiopian immigrants and their doctors in Israel, Reiff, Zakut and Weingarten (1999) observed many misunderstandings between immigrant patients and Israeli doctors. These emerged from the biomedical model's inadequacies when dealing with culture-based discrepancies in the conceptualisation of illness and healing. Reiff et al. further suggested that these dissonances are further pronounced when foreign patients present with conditions that the Western biomedical model has not previously come across before and therefore finds it hard to account for. Having said that, all is not lost because, Western medicine seems to be gradually moving towards recognising other causes of illness, for example sociological causes of illness (Lakhan, 2006).

In summary, the Western biomedical model largely is still reductionist in its conceptualisation and treatment of illnesses. Western medicine further makes little if any reference to spirituality or religion in its theory of illness (Hammond-Tooke, 1989; Taylor, 1997).

2.3.3 Convergence and divergence between the Western and traditional healing models

From a distance and particularly in the absence of knowledge of and experience with traditional African healing, the two orientations might seem far apart. However, when they are more closely observed, they are seen to have overarching aim in common: to prevent known prospective illnesses whilst dealing effectively with existing ones (Hammond-Tooke, 1989).

In terms of diagnostics and the treatment of some illnesses, there may be areas in which traditional African healing lags behind Western healing. Equally, in terms of remedies and plants extracts (discussed later) or indigenous knowledge systems, there are areas in which the Western healing model could learn from traditional African healing.

It has been stated that the focus in the traditional health model, as compared to the Western health model, is on the holistic restoration of a homeostasis among the body, the mind, and the spirit (Van Dyk, 2008); and that patients in the traditional model are not seen as passive victims but rather as actively involved in the restoration of their health, and that this involves significant others who provide an invaluable social support to facilitate speedy recovery (Mulato & Berry, 2001). However, this approach can also be seen in the Western healing systems, where a more holistic approach is being followed and family members of the patient are encouraged to be part of the healing process.

One of the cardinal differences between the traditional and Western healing models is the epistemological question. Alderete (1996) defined epistemology as the theory of how people come to have knowledge of the external world. In the case of the traditional healing paradigm, knowledge is gained from both the trainer and the spirits of the departed whilst in the Western healing paradigm students attend universities or colleges to learn about the physiology or the anatomy of the organism.

Because of the positivistic and empiricist Western model, the guidance of the spirits of the departed that are the basis of traditional healing are rendered problematic because they cannot be directly observed by using the objective scientific methods that are the corner-stones of the Western model. This is based on the premise that Western science's subject matter should be observable, and that anything that cannot be directly observed should be discarded because 'there is no way a subjective phenomenon can be verified'. However, according to Barsh (1997), the Western method of empiricism can also be applied to determine the bioactive and medicinal content of traditional pharmacopoeia.

Unfortunately, with Westernisation, there have been deliberate attempts to subjugate the African psyche. One of these was to discredit the traditional African healing model by labeling it as barbaric and backward. Despite the Westernisation of Africans through urbanisation and education, belief in the traditional African healing model remains firm and the notion that rapid technological, technical and pharmacological advances in Western medicine will ultimately supplant traditional healing in its entirety can be regarded as a myth (Blaustein, 1992; Bye & Dutton, 1991).

2.4 CONCLUSION

Particular philosophies about sickness and health have persisted throughout centuries because people who subscribe to them generally find them convincing (Young, 1976). The biomedical model takes its cues largely from the Western cultural assumption that traditionally separated the mind from the body and emphasises scientific objectivity, whereas in traditional cultures illness is viewed and treated in a holistic manner that includes the body, mind, spirit, community, extended family and universe (Reiff et al., 1999). In other words, the biomedical model often addresses only physiological symptomatology while the traditional healing model goes beyond physiology by tackling the metaphysical aspects of wellness (Gurley et al., 2001).

Although there may be problems associated with both models, it would not be reasonable to reject either: to throw the baby out with the bath water. There are invaluable lessons to be learned from both models. Tumwesigye (1996) found the Western medicine to be expensive but very valuable for its knowledge of hygiene, scientific diagnostics and explanations for diseases as well as the healing process. African medicine on the other hand

is relatively inexpensive and is invaluable for its knowledge of medicinal plant extracts and the holistic approach to health care. A balance between traditional African healing and Western healing could be created by way of co-existence and collaboration at the formal level in view of the fact that in nearly every cultural setting, health care systems are pluralistic (Bodeker, 2001; Neumann & Lauro, 1982).

The following chapter gives a detailed review of the literature on traditional healing on the African continent. The weaknesses and strengths of traditional healing as well as international opinion on traditional healing are discussed.

CHAPTER THREE

TOWARDS THE INTEGRATION OF TRADITIONAL HEALING AND WESTERN HEALING: IS THIS A REMOTE POSSIBILITY?

3.1 INTRODUCTION

Health care in Africa is an emotive and complex issue that needs to be thoroughly investigated. Throughout the continent, HIV and Aids, tuberculosis, malaria, cholera, psychiatric conditions and other diseases are wreaking havoc especially in poorer communities (Fennell et al., 2004; Lienhardt et al., 2001). The impact of HIV infection and Aids is so vast that verbs like 'decimate' have been used to describe what this disease has done to the people of Africa (Pesek et al., 2006). The trail of destruction that continued until very recently was predicted as early as the late 1980s (Savage & Shisana, 1994).[2]

Aids has overtaken other illnesses to become the leading cause of death in Southern Africa, and its huge negative impact continues unabated (Airhihenbuwa & Webster, 2004; Hatchett et al., 2004). South Africa is one of the severely affected countries in the region (Lesch, Kafaar, Kagee & Swartz, 2006; UNAIDS, 2010). Although the rate of infection in the adult population in Southern Africa as a whole remains high and life expectancy is significantly lower than before Aids became part of the health equation, the infection rate appears to have stabilised (Chirambo, 2008; UNAIDS, 2010). Existing hospital infrastructure is inadequate to deal with Aids-related illnesses (Harding, Stewart, Marconi, O'Neil & Higginson, 2003). This is evidenced by the involvement of Christian charismatic groups in some clinics and hospitals in Africa where medical personnel are scarce (Krause, 2006).

Each year, malaria kills more than one million people in sub-Saharan Africa (Campbell & Steketee, 2011; Oberlander & Elverdan, 2000). It is one of the leading causes of death for both young and old in many parts of Africa (Makundi, Malebo, Mhame, Kitua & Warsame, 2006). To further add to this problem, cholera outbreaks are sporadically reported in the poorer rural areas in sub-Saharan Africa such as Zimbabwe. When such outbreaks occur in Zimbabwe, many patients cross the border to seek medical assistance at the South

[2] These days the situation is much better in countries where HIV and Aids awareness is relatively high and ARVs are readily available and accessible to those who need them.

African state hospital in Musina (as, for instance, in 2008) (Talk Radio 702, 2008). When large numbers of patients do this, medical resources at the hospitals affected were overstretched. The Institute for Communicable Diseases (ICD) was reported as been extremely worried about that outbreak and the impact that it had on the South African health care system which could barely cope with the influx of patients. The ICD remains concerned that cholera outbreaks can occur at any time if poverty and lack of medical resources in Zimbabwe do not improve. In times like these, there may be calls for the integration of traditional healing into the mainstream health care system to reduce the burden that the Western healing system is carrying. Such calls were being made even before the 1994 democratic dispensation in South Africa (Hammond-Tooke, 1989). The move to integrate the two systems was fully supported and advocated for by the previous and late minister of Health in South Africa, Dr. M. Tshabalala-Msimang and previously endorsed by the Member of the Executive Committee (MEC) for Health in the Kwazulu-Natal province, P. Nkonyeni (Jordan, 2008).

All over the world the traditional healing system has captured the attention of scholars for many decades (Incayawar, 2008). Interest among academic researchers, particularly cultural anthropologists, resurfaced in the late 1950s and early 1960s when African countries such as Ghana and Nigeria gained their political independence from the Western political and cultural imperialism (Cocks & Dold, 2000). This interest gained greater momentum in the 1980s and into the new century, with the emancipation of the last batch of African countries (Addis, Abebe, Genebo & Urga, 2002; Ataudo, 1985; Baleta, 1998; Barsh, 1997; Berg, 2003; Bishaw, 1991; Buhrmann, 1984; Burford, Bodeker, Kabatesi, Gemmil & Rukangira, 2000; Gort, 1989; Green, 2000a; Green, 2000b; Haram, 1991; Hopa et al., 1998).

South Africa, being one of the last countries in Africa to gain political independence, in mid 1990s reformulated its health care policy to include traditional healing in the mainstream health care (Hopa et al., 1998). This move to reformulate policy around traditional healers would have been expected, as the majority of African governments reformulated their health care policies after independence (Freeman & Motsei, 1992). When governments reformulate these types of policies, extensive research is often encouraged and many researchers become interested.

What seems to attract the attention of academic researchers to the area of traditional healing is the etiological question of illness which includes witchcraft, the role of the spirit of

the ancestors and the use of magic (discussed in Chapter 2). The demand for the traditional healing system in the African communities is another aspect that attracts academic researchers' attention to this area (Corin & Bibeau, 1980).

3.2. DEMAND FOR TRADITIONAL HEALING

Traditional healing used to be concentrated mainly in the rural areas of Africa because of the inclination towards the traditional way of living in those areas. However, in the 21st century this seems to have changed. Traditional health care services are no longer confined largely in rural traditional villages but have spilled over into the urban and semi-urban areas with the influx of people from rural to urban areas in search of better economic conditions. To corroborate this, McKean and Mander (2007) alluded to the process of rapid urbanisation, HIV and Aids as well as high levels of unemployment as factors contributing to the high demand for traditional African medicines and stated that this demand is probably higher than at any time in the previous century. There is no city, town or village in Africa where the services of traditional healers are not in high demand (McCallum, 1992).

People consult with traditional healers for a variety of reasons ranging from checking up on how their lives are working out to seeking treatment for serious diseases like '*mafofonyane*' (schizophrenia) and pandemics such as Aids. Popular traditional healers benefit from such pandemics and are able to attract patients from as far away as neighbouring countries. It is not unusual to have a South African healer who has clients in countries including Botswana, Lesotho, Zambia, Zimbabwe and others.

Thus, Green (1988) argued that many traditional healers have succeeded in establishing financially profitable practices in their countries, and that some of these lucrative practices are located in urban areas where Western medicine is readily available. He gave the example of healers who may take patients away from Western-trained medical practitioners, as can be seen in Lagos (Nigeria) where a number of traditional healers have accumulated substantial capital and have built multi-bed hospitals with sophisticated modern medical equipment that can match those in the Western oriented medical facilities. Similar occurrences can also be seen around large South African cities such as Johannesburg, Durban, Cape Town and Pretoria where some traditional healers are buying multi-roomed office blocks and transforming them into lucrative traditional health care clinics (Hlongwa,

2008). These and other reports suggest that traditional healing is in high demand in African communities.

The demand in many countries has outpaced policy development regarding the integration of traditional healing into the mainstream health care system (Bodeker, 2001). As a direct response to the demand for traditional healing, some African governments are moving towards officially recognising traditional healing in their respective countries. However, this move is resisted by part of Western-trained health care practitioners in countries such as Nigeria (Abdullahi, 2011). Traditional healers in South Africa and elsewhere on the African continent seem not to be close to being formally integrated into the mainstream health care system (Abdullahi, 2011; Baleta, 1998). The move to integrate traditional healing and Western medicine will require extensive research into its practicality and potential problems. It does not appear that the present government in South Africa has commissioned any large scale, countrywide research to that effect, notwithstanding the popularity and the number of practicing traditional healers in the country (Government Gazette, 2008).

3.2.1 Proportion of traditional healers to the general population of users

It has long been clear from the literature that traditional health care practitioners provide most of the medical care at primary level to both rural and urban African communities (Campbell, 1997; Imperato, 1981). These practitioners are found in large numbers and are therefore easily accessible to the people who need them most. In South Africa, the ratio of traditional healers to the general population of users of their services has been estimated to be 1:500 and that of Western medical practitioners to be 1:40 000 (Crawford & Lipsedge, 2004; Truter, 2007). These figures are similar to those reported in Tanzania (Stengeland, Dhillion & Reksten, 2004). In Mozambique, the ratios are 1:200 and 1:50 000 respectively, and in Swaziland 1:100 and 1:10 000 respectively (Gbodossou, Floyd & Katy, n.d.).These ratios speak to the issue of scarcity of Western-trained health care practitioners in comparison with traditional healers who are abundantly distributed among the general public. This raises the question about who utilises the services of traditional healers in the African communities.

3.2.2 Age, education level and choice of healing system

In South Africa, as in many African countries, the traditional African healing system has been a fundamental but unrecognised component of the general health care system (Puckree, Mkhize, Mgobhozi & Lin, 2002). Nyika (2007) and Vontress (1991) argued that the majority of people who use the services of traditional healers do so because Western medicine is not easily accessible to them and most of them are illiterate. Contrary to Vontress' argument, it would appear that for many decades Africans' level of education and religious beliefs did not necessarily determine the likelihood of their consulting traditional healers when the need to seek health care arose (Harries, 1929). Many educated and middle-class Africans, young and old, still uphold their traditions and customs and continue to consult with both traditional healers and Western-trained medical practitioners depending on their perception of the conditions they want to consult about (Cocks & Dold, 2000). Even the technological advances in Western medicine do not seem to overshadow the popularity of traditional medicine (Blaustein, 1992).

It is common among Africans to think that those (Africans) who consider themselves 'Westernised' and therefore 'civilised' tend to consult with Western medical practitioners during the day and with African traditional healers at night when people cannot see them. It is also generally thought that people do so to reduce cognitive dissonance that might be caused by, amongst other factors, orthodox and charismatic Christian teachings as well as Westernisation that frown upon the use of traditional healing (Chavunduka, n.d.). However, MacLachlan and Carr (1994) contended that cognitive dissonance does not exist in many people who make use of both health care systems. There is in fact, according to them, cognitive tolerance because consumers believe that there is nothing wrong with using both systems as both seem to work well for them.

It is noteworthy that Satimia, McBride and Leppard (1998) reported different results and advance different reasons for the choice between traditional healing and Western healing. They found that in rural Tanzania age and education influence the choice of health care, with people aged between 15 years and 34 years leaning more towards Western healing because of Western education whilst those aged 55 years and older lean more towards traditional healing because many in this age bracket have not been formally schooled and have been brought up using traditional medicine.

On the question of age, contrary to Satamia et al. (1998), Edginton, Sekatane and Goldstein (2002) found that, at one of the rural villages in the Limpopo province, South Africa, people aged 15 and older consulted traditional healers before and after consultation with medical doctors and clinics. This discrepancy might be explained by the level of formal education of the respondents in this study, with most having fewer than four years of formal schooling. In some cases, the education level may play a role in health care choices.

Overall, much of the literature points to a collaborative approach to the complex issue of health care, and shows that traditional healing is in high demand in the rural and urban areas of South Africa and elsewhere on the African continent. In many studies, age, education level and social standing of African respondents did not play a major role in people's choice of healing, which seemed to be based on cultural perception of illnesses and the efficacy of traditional healing. Such efficacy is an aspect that continues to be debated and discussed internationally.

3.3 EFFICACY OF SOME HERBAL REMEDIES (PLANT EXTRACTS) IN TRADITIONAL HEALING

In a Zimbabwean study of the effectiveness of African traditional herbal remedies used for the treatment of urinary *schistosomiasis (*a parasitic infection common in sub-Saharan Africa and also known as bilharzia), Ndamba, Nyazema, Makaza, Anderson and Kaondera (1994) reported that *Abrus precatorius*, a legume with long leaves, *Ozoroa insignis*, an African resin-tree with a kidney-shaped edible fruit, and *Pycnanthus angolensis*, used in traditional medicine as an anti-inflammatory medication, were significantly effective in reducing the *schistosomiasis* parasites. These results were replicated by Sparg, Van Staden and Jager (2000) in a South African study conducted in Kwazulu-Natal province where it was found that these plant extracts kill up to 100% of the *schistosomula* worms. In addition to *Pycnanthus angolensis* being used for *schistosomiasis*, Gbolade and Adeyemi (2008) found that traditional healers in Nigeria use it effectively as an analgesic (painkiller). It is noteworthy that *schistosomiasis* continues to spread in sub-Saharan Africa and in some cases it is reported to be resistant to some modern medical treatment (Ross et al., 2002).

Many plant extracts used in African traditional healing system have been found to be effective in treating conditions including malaria, depression, Alzheimer's disease, varieties of inflammations, bacterial infections and epilepsy (Fennell et al., 2004; Good et al., 1979; Huxtable, 1992; Moshi, Kagashe & Mbwambo, 2005). For example, Shale, Stirk and Van Staden (1999) screened many medicinal plants used in Lesotho for anti-bacterial and anti-inflammatory purposes, and found that the majority of those plant extracts have very high anti-bacterial and anti-inflammatory properties. Similar findings were more recently reported by Afolayan, Aboyade, Adedapo and Sofidiya (2010).

Varga and Veale (1997) studied utilisation patterns and potential health effects of a traditional herbal medicine called *isihlambezo* (Zulu), used during pregnancy. *Isihlambezo* is mainly used for adequate fetal growth and is also thought to be aiding in a quick and smooth labour process (Brookes & Smith, 2003). Varga and Veale conducted interviews with 218 pregnant and non-pregnant women in both rural and urban areas. Their research participants included women who attended, and those who did not attend modern clinics. They found that over 80% of participants in both groups advocated the use of *isihlambezo* because of its superiority over modern medicine. Of interest to note is that, contrary to popular belief that urban women choose Western healing over traditional healing, the study found that more urbanites than rural dwellers opted for *isihlambezo*.

With such evidence about the effectiveness of traditional herbal remedies, one would have thought that there would be formal cooperation between traditional and Western healing. Instead, Shale et al. (1999) have found a one-way process where traditional healers in Lesotho refer patients to Western medical practitioners without the latter reciprocating.

As is the case in Lesotho, much research on traditional healing still needs to be done in South Africa. The mooted process of the integration of the two health care systems seems to be underway, albeit at the snail's pace. This progress has been made despite the fact that South African health care literature has not reached consensus on the nature of collaboration between the two (Yen & Wilbraham, 2003). Local and international public debate, and formal discussions at the levels of non-governmental organisations, government and academic researchers, continue (Shizha & Charema, 2012).

3.4 INTERNATIONAL DISCOURSE ON TRADITIONAL HEALING

International and particularly Western opinion is generally skeptical about traditional health care practices and health care systems, which are considered 'unscientific' (Dunlop, 1975). However, this skepticism does not go unchallenged, with some researchers viewing it as a form of resentment towards traditional African healers. Green (1988) argued that such resentment by Western health care practitioners has probably grown in the past due to the development among traditional African healers of what can be called 'professionalisation'. What Green implied was that traditional African healers were becoming more organised and advanced in their practice and tended to be trusted by consumers of their services.

Such negative opinions about traditional healing systems seem gradually to be changing, as more and more Western-trained health care practitioners and researchers experience traditional healing in a range of ways. This experience comes about as a result of formal or informal collaboration with traditional healers. This has been encouraged by, amongst others, the Declaration of Alma Ata. In 1978, the joint conference of the WHO and the United Nations Children's Fund (UNICEF) in Alma Ata, Kazakhstan, took a resolution to support the integration of traditional healing in government hospitals and clinics globally (Green, 2000a). The resolution aimed at ensuring that primary health care is accessible to everyone including the large underserved populations of the developing world (Neumann & Lauro, 1982).

The WHO and other bodies have also begun to acknowledge the potential effectiveness of traditional healers as primary health care providers and the potential efficacy of their treatments in the fight against illnesses such as Aids, sexually transmitted infections (STIs) and other communicable diseases. It is therefore not surprising that traditional health care practitioners begin to carry much of the clinical burden resulting from the Aids pandemic (Mills et al., 2005). To relieve them of this burden, the WHO encouraged the training of more Western-educated health care practitioners as well as reciprocity in the form of referrals of patients between the two health care systems (Hewson, 1998; Zhang, 2000).

It further encouraged governments to actively recruit traditional healers particularly into their primary health care systems so that the Healthy People 2010 initiative could be achieved (Gort, 1989). This was an initiative aimed at reducing health disparities among peoples (Struthers, Eschiti & Patchell, 2004), with traditional medicine being expected to

play a crucial role in achieving this aim. This was because traditional healing is viewed as effective by the consumers and as "*the medicine of the people by the people and for the people and it is the first contact medicine*" (Ataudo, 1985, p.1345). However, the evaluation of the progress of Healthy People 2010 plan indicated that little progress has been made and that much needs to be done to eliminate health disparities among different groups of people by 2020 (Koh, Piotrowski, Kumanyika & Fielding, 2011; Sondik, Huang, Klein & Satcher, 2010).

In many parts of the world, there seems to be a general preference for traditional healers because of the warm atmosphere that they create as opposed to the not so warm, clinical atmosphere in physicians' private practices, clinics and hospitals (Hilgenkamp & Pescaia, 2003). The WHO and other organisations in the health care sector have regularly advocated for the reversal of the culturally biased and disparaging premise that perceives traditional healers as quacks whose practice does not belong in modern times and should therefore be eliminated and replaced by Western scientific knowledge and practice (Bibeau, 1985; Gort, 1989).

In summary, international opinion seems to be gradually becoming more favourable towards traditional healing and its inclusion in the primary health care system throughout the world. This is further attested by, among others, the World Health Assembly (WHA) which encourages training and more research in the area of traditional healing (Green, 2000a).

3.4.1 Western-trained health care practitioners' perceptions and attitudes towards traditional healing

In Ethiopia, Addis et al. (2002) looked at perceptions of modern health care practitioners about traditional healing. Although their sample size was relatively small (n=14), their findings are worth noting and could be a good indicator of how other Western-trained health care practitioners feel about traditional healing. The study found that many modern health care practitioners had consulted with traditional healers at least once in their lives and believed in the effectiveness of traditional healing in dealing with some illnesses. However, the study did not mention whether those Western-trained health care practitioners who

consulted with traditional healers in the past did so before or after they had qualified as health care professionals.

The study also reported that over 80% of the 14 modern health care practitioners were in favour of formal integration of the two health care systems. Ethiopia seems to have had a positive attitude towards traditional healing after the change of government in the mid 1970s (Bishaw, 1991). The same can be said about the Democratic Republic of the Congo which favours the integration of the Western and traditional African healing systems (Bibeau, 1985).

In south-western Nigeria, Odebiyi (1990) studied the perceptions of 55 Western-trained nurses about the different categories of traditional healers, and found that they had positive perceptions about the healers and their integration into the mainstream health care system. The nurses thought that it would be mutually beneficial for both health care models if they worked together. Western orthodox medicine would benefit from traditional medicine in the areas of psychiatry and other ailments believed to have been caused by supernatural forces, while traditional medicine would benefit from Western mainstream medicine in the area of diagnostics and in surgical skills.

Part of the above view concurs with other researchers' assertion that traditional medicine has some strong points that Western medicine lacks, namely a holistic view of the patient's situation (Ataudo, 1985; Jager, 2005; Petersen, 2000; Van Dyk, 2008). Jager further stated that, in traditional practice, psychological, spiritual and social aspects play a large role and that this holistic treatment can to some extent make up for the often weaker aspect, the medicinal treatment, compared with Western biomedicine.

Last (1981) found that Western-trained medical practitioners in Nigeria tend to have a general attitude of 'do not know, or do not want to know' about traditional healing. Last's findings may need to be understood in the context and the era in which his research was conducted, in the 1960s, when European cultural imperialism was still largely intact in Africa although some African countries were gaining political independence from their colonial masters. In that era, people were still taught to despise many African practices which included, amongst others, African religion and African medical practice; this was the context of these findings.

In Swaziland, Upvall (1992) looked at nurses' perceptions of collaboration with indigenous healers. She found that religious affiliation and clinical setting may affect perceptions of collaboration. For example, government nurses in rural settings indicated a need for a national health policy to structure collaboration efforts, while nurses in state hospitals in urban settings were ambivalent or expressed negative perceptions towards collaboration. One might suspect that this is the case because the way of life in rural communities tends to be more traditional (hence the positive perception and negative perceptions on the part of nurses in rural areas and urban areas respectively) than in the cities. In addition, nurses affiliated to Zionist churches and African independent churches indicated more willingness to collaborate with traditional healers. Zionist churches and African Independent churches tend to incorporate aspects of traditional healing in their practice. In an earlier study, Hoff and Shapiro (1986) found that attitudes between Western-trained nurses and traditional healers were more positive and that communication and cooperation increased after a joint workshop between the two groups. Over 90% of traditional healers in this study indicated that they would like to see better cooperation between themselves and Western-trained medical practitioners (Green & Makhubu, 1984). Such cooperation between Western-trained health care practitioners and traditional healers could enable the two health care systems to better share the health care services load. Traditional healers think that Western medical practitioners tend to deal with symptoms of the disease whilst they themselves deal with the root cause of diseases such as witchcraft (Green, 1985).

In Zambia, over 50% of Western-trained health care practitioners who took part in the study were found to have a positive attitude towards collaborating with traditional healers in HIV training and patient care (Burnett et al., 1999). In turn, over 90% of traditional healers there showed a positive attitude towards working with Western-trained health care practitioners (Burnett et al., 1999) and over 80% of traditional healers in neighbouring Botswana were harmoniously working hand-in-hand with Western medical practitioners (Chipfakacha, 1997).

As can be seen in the literature reviewed here, there are mixed findings about the perceptions of Western-trained medical practitioners regarding traditional healing. However, many practitioners seem to lean towards a formalised collaboration with traditional healers. Generally speaking, Western-trained health care practitioners seem to have positive

perceptions and attitudes towards traditional healing although some of the literature reported negative attitudes, particularly on the part of physicians (Hopa et al., 1998).

3.5 POSSIBLE INTEGRATION OF TRADITIONAL HEALING AND WESTERN HEALING

Given the documented effectiveness of some herbal remedies in treating diseases in traditional healing, Pearce (1982) investigated the possibility of integrating the Western and traditional health care systems in Nigeria. He found that although physicians were in favour of collaboration between the two systems, they would rather collaborate with only one category of traditional healers (herbalists) as the physicians are more interested in herbal remedies than other forms of traditional healing such as divination. The physicians furthermore believed that the efficacy of traditional healers' herbs could be subjected to rigorous empirical analysis as opposed to the use of spirits which is abstract and subjective and therefore cannot be subjected to Western scientific methods of analysis.

Hopa et al. (1998) have looked at perceptions of the integration of traditional healers and Western healing in South Africa. The study was carried out early in South Africa's democratic dispensation. They separated their focus groups into psychiatrists, medical doctors, consumers, traditional healers and psychologists. They found that the doctors' group was skeptical about integration and questioned the authenticity of traditional healing practices. The group also thought that traditional healers were mostly illiterate. It is not clear how the literacy level of traditional healers is connected to their trade since traditional healing or its training does not depend on the practitioners' ability to read or write although being literate could help traditional healers in terms of writing prescriptions and not simply giving prescriptions by word of mouth.

Contrary to the attitudes of the doctors' group, Hopa et al. (1998) found that focus groups consisting of psychiatrists favoured informal cooperation, which they were already practicing, as well as a more formal integration. This raises the question of why there are these differences in attitudes towards collaboration between the two groups of doctors. Hopa et al. did not fully explain their view on these, however one may suspect that they result from experience with traditional healing or lack thereof. This experience might have come about as

a result of health care practitioners having collaborated with traditional healers or of having used the services of traditional healers themselves. Some psychiatrists seem already to be working in collaboration with traditional African healers and have possibly witnessed the efficacy of the traditional health care system. It could also be the case that psychiatrists and traditional healers tend to work more with psychiatric cases than physicians do.

Ghana seems to have taken considerable strides towards integration of the two health care systems. Programmes have been put in place to expose doctors to traditional healing by introducing a postgraduate diploma course in traditional medicine at one of Ghana's leading medical schools (Tsey, 1997). However, the project to fully integrate traditional healing and Western healing in that country still has a long way to go (Kavi, Abanga, Kudolo & Morna, 2008), and it remains to be seen how successful this move is in the long run and how far other countries can learn from Ghana's experience. The move to integrate the two health care systems there and elsewhere is applauded by organisations that advocate traditional healing, such as the one discussed below.

3.5.1 The Association for the Promotion of Traditional Medicine (PROMETRA)

Across the continent of Africa, there exist associations of traditional healing such as the Association for the Promotion of Traditional Medicine (PROMETRA) which has its headquarters in Dakar, Senegal and regional offices across the continent including one in Sunnyside, Pretoria, South Africa. PROMETRA hosted the first international convention on traditional medicine and Aids in Dakar, Senegal in 1999 (Burford et al., 2000). Their objective is to preserve African traditional healing and indigenous knowledge system through research, education, advocacy and practice throughout the world (Gbodossou et al., n.d.). They further advocate for formal recognition and reciprocal relationships between the Western healing and traditional healing systems. The achievement of formal recognition and harmonious relationships between the two might lead to a mutual trust between them. Currently, however, there are aspects of traditional healing practices that lend themselves to criticisms from both consumers and from other health care practitioners.

3.6 CRITICISMS OF TRADITIONAL HEALING

A number of criticisms appear in the literature on traditional healing. It is accepted that professions need to be regulated so that consumers are adequately protected from abuse and malpractice. This does not appear to be the case with the profession of traditional healing. Although there are traditional healer organisations in South Africa and elsewhere on the African continent, the traditional healing system is porous and largely unregulated and the regulatory capacity of governments is limited particularly with regard to the harvesting of medicinal plants by traditional healers (De Beer, 2010; Fennell et al., 2004). Consequently, there are many traditional healers who practice without proper registration or without belonging to an association of any sort. There are also individuals who are not qualified as traditional healers but make their way into the system and masquerade as traditional healers for economic reasons (Yeboah, 2000). Most of such cases are found in the cities where people will do anything to earn a living. Frequently, newspapers and magazines carry articles about people, supposedly traditional healers, who claim to have found a cure for Aids and almost all kinds of illnesses imaginable (Richter, 2003). People living with HIV or Aids are conned by bogus doctors calling themselves 'Dr Mamas' and mainly operating in Johannesburg, Pretoria, Durban and Cape Town (Lombard, Cullinan & Thom, 2008). They are called 'Dr Mamas' because their names are preceded by the title 'Mama', such as Mama Eva or Mama Helen. The bogus 'Dr Mamas' advertise their services in small pamphlets distributed to people in the streets of Johannesburg and other towns and cities in South Africa. According to the pamphlets, the 'Dr Mamas' claim that they can 'cure' any disease and condition as well as rectifying any situation imaginable. For example, some claim that they can reverse a divorce situation in which one partner has already left the marriage.

Apart from the problems with "Dr Mamas', some genuine traditional healers have been found to give little attention to the critical issue of hygiene (Green & Makhubu, 1984). In some cases, traditional surgeons have been accused of inadvertently increasing the spread of HIV by using the same unclean surgical instruments such as razor blades and knives on different patients (Mills et al., 2005). However, in Botswana, Chipfakacha (1997) found that traditional healers encouraged patients to bring their own surgical/sharp instruments or that they used their own disposable instruments.

Another practice that draws criticism from Western-trained health care practitioners and the general population is the method of cupping or blood-letting. This refers to the

procedure in which a traditional healer sucks an affliction out of the patient's body by using a tennis ball and in some cases using their own mouth (Gelfand, 1967). This is problematic and potentially dangerous because HIV and other blood-borne conditions can be transmitted from one person to another with this method.

Some traditional healers have been criticised for displaying a lack of knowledge of widespread diseases such as malaria. Malaria kills millions of people yearly and there are traditional healers who have a completely incorrect knowledge about the causes of the disease, with some thinking that severe malaria is caused by the heat of the sun, oily food and even too much work (Gessler, Msuya, Nkunya, Schar, Heinrich & Tanner, 1995a; Okeke, Okafor & Uzochukhwu, 2005).

There are concerns regarding the depletion of plants used for medicinal purposes without an attempt by traditional healers to replenish such resources (Gessler et al., 1995b). To circumvent this problem, a suggestion has been made by interested organisations such as the KwaZulu Natal Bureau of Natural Resources and the Institute of Natural Resources at the University of KwaZulu Natal to introduce commercial cultivation of such plants by subsistence farmers (Bye & Dutton, 1991). This could help to alleviate dependency on expensive Western pharmaceuticals, as well as taking care of the health needs of majority of Africans. In other parts of Africa such as Uganda, such interventions are already in place and some traditional healers themselves have herbal gardens (Richter, 2003). However, commercially producing plants in the backyard for medicinal purposes may be problematic for traditional healers who take pride in telling their clients/patients and acquaintances that their medicines are not from nearby. It is very common to find traditional healers who tell their clients that the medicines they prescribe are very strong and effective and cannot be found in the neighbourhood. These tend to be medicines for serious illnesses and for the fortification of life and property. The most recent example of traditional healers' role in the fortification of life was witnessed in Marikana, near Rustenburg in South Africa, where striking Lonmin miners used the services of a traditional healer to make them invincible. Despite the traditional healer having 'fortified' them against police guns, over 30 striking miners died. Nevertheless, some miners believed that had it not been for the traditional healer's fortification many more lives could have been lost on that day (News24, 2012).

Critics also see the use of animal parts in traditional healing as problematic. Vultures, African rock pythons, dwarf chameleons and other animals are killed for the purposes of

traditional healing and this practice could lead to the extinction of these animals in the coming decades if nothing is done to stop it (McKean & Mander, 2007). Besides animal parts used in traditional medicine, the media occasionally report on traditional healers or their agents killing people and removing body parts to be used as medicine (*muti)*. Other media reports include criminals smearing '*muti*' over their bodies. It is believed that this makes criminals invincible and that police find it difficult to catch them. Many criminals still however are caught and sometimes even get killed by police, despite having been 'fortified' by traditional healers. If these reports are correct, then some traditional healers have a hand in the escalating crime rate in South Africa.

The transfer of knowledge is another weakness in traditional healing. Knowledge is by and large not well documented because of the general lack of literacy on the part of many traditional healers, as Asuni (1979) pointed out, and even traditional healers who are highly literate and educated continue with the tradition of not putting traditional healing knowledge in writing. This practice could, however, also be attributed to the belief that oral transfer of knowledge is more powerful than the written word. Knowledge is generally handed down from generation to generation through word of mouth or can be transferred from the ancestors to their descendants through dreams and visions (Cullinan, 2008). As a result, knowledge can be misrepresented, diluted or even lost with the passage of time (Asuni, 1979).

These criticisms and other factors may hinder the proposed integration of traditional healing and Western healing.

3.7 ANTICIPATED HINDRANCES TO INTEGRATION OF TRADITIONAL HEALING AND WESTERN HEALING

The integration of the two health care systems promises to be a complex issue. Courtright et al. (2000) have identified four possible barriers to the integration of the two health care systems:

- There will be economic and prestige competition between the two systems. This view was also shared by Green (1988).

- Western-trained health care practitioners are generally reluctant to collaborate with traditional healers because of the perception that traditional healers practice in a way that may be harmful to their clients.
- Western-trained health care practitioners may perceive traditional health care practice as illegal.
- Western-trained health care practitioners tend to think that collaborating with traditional healers may legitimise inappropriate traditional healer practices.

Freeman and Motsei (1992) have identified two additional barriers to the integration of the two health care systems in South Africa:

- The State's health care budget is overstretched and health care personnel are underpaid. Bringing over 150 000 more personnel, in the form of traditional healers, into the health care system will be practically challenging.
- The registration of traditional healers has not been fully achieved anywhere in the world.

Some of the abovementioned concerns were shared by Doctors for Life (DFL). This was evidenced in a letter written by the then president of DFL to the editor of the South African Medical Journal in which the DFL was clearly against the integration of the two health care systems. One of the reasons advanced by DFL was partly based on religious convictions. DFL stated that the organisation "*upholds sound scientific principles and basic Christian ethics in the medical profession*" (Van Eeden, 1993, p.441). Van Eeden further claimed that 'numerous black people have begged' DFL to make sure that traditional healers are kept out of the future health care system in South Africa. It is noteworthy that Van Eeden did not quote the exact number of black people and black doctors that were supposedly against the inclusion of traditional healers in the health care system in South Africa nor did he say exactly how many black people begged the DFL to prevent traditional healers from being part of the primary health care system. Without figures to validate his claim, the letter remains an opinion piece. It should however be noted that the letter was written almost 20 years ago, and opinions may have changed since then.

Most of the barriers discussed above are claimed to have been overcome in some African and Asian countries where traditional healing and Western healing are working in collaboration with each other. It is reported that Uganda's HIV infection rate has declined apparently as a result of the government's having included traditional healing in addition to Western medical practitioners and other concerned organisations in training and management of the disease (Green, 2000b). The report was not specific about how much of an impact traditional healing has had in the fight against HIV in Uganda; it reported only on the general involvement of traditional healers in the fight against Aids.

In South Africa, efforts to train traditional healers in HIV management began some time ago (Green et al., 1995). In Kwazulu-Natal, Peltzer, Mngqundaniso and Petros' (2006) study on HIV/Aids/STI/TB knowledge, beliefs and practices of traditional healers found that more than 50% of the traditional healers that they studied were already involved in the referral of patients for HIV testing and management. If efforts to fight the Aids pandemic in Africa do not include African traditional healing, the majority of Africans will not be reached and such efforts may not produce the desired result of ridding the continent of the pandemic (Gbodossou et al., n.d.; Homsy, King, Tenywa, Kyeyune, Opio & Balaba, 2004). However, problems regarding the collaboration of the two health care systems stem from the traditional healers themselves, who are generally viewed as secretive about their work.

3.7.1 Trust and secrecy on the part of traditional healers as barriers to integration

Judging by the public debates and the literature on traditional healing, trust and secrecy on the part of traditional healers are some of the issues affecting the relationship between traditional and Western healing systems across the African continent. The issues of trust and secrecy might be a barrier to formal cooperation between traditional healing and Western medicine. This secrecy comes about as a result of a common fear amongst traditional healers that Western scientists will appropriate their ideas about medicinal plants and roots and modify them as if they are theirs. The secrecy relates mainly to the protection of traditional healing practices because information about herbs and healing is privileged information shared only amongst the initiated (Lazarus, 2006; Ubrurhe, 2003).

The issue of secrecy could be circumvented by governments and other health care authorities making deliberate efforts to protect the intellectual properties of traditional

medicine as is the case with Western pharmaceutical companies (Nyika, 2007; Timmermans, 2003). In some cases, Western scientists succeed in gaining the trust of traditional healers as was the case in Zimbabwe where the Research Council of Zimbabwe collaborated with the Zimbabwe Traditional Medical Practitioners Council in research on a number of diseases (Chipfakacha, 1997). In other parts of the world, the non-integration of the two health care systems poses some dilemmas.

3.8 DILEMMAS POSED BY NON-INTEGRATION OF THE TWO HEALTH CARE SYSTEMS

Research in traditional healing has established the effectiveness of the traditional pharmacopoeia in the treatment of some illnesses. Researchers have made recommendations to governments to officially recognise and integrate traditional healing into the mainstream health care system to alleviate pressures on the Western health care system, particularly in developing countries. Many of these in sub-Saharan Africa have not yet effected such integration. The delay in integration of the two health care systems does not seem to preclude the majority of people in these countries from continuing to enlist the services of modern and traditional healers without realising how potentially dangerous it may be if the two do not communicate about the remedies that they simultaneously administer for the same illnesses to the same consumer. The individual consumer is torn between the two health care systems because he or she may not know the etiology of his or her illnesses and move from one health care system to another because of different teachings and beliefs about the origins of illnesses.

There are health care practitioners (doctors and nurses) who themselves enlist the services of traditional healers and advocate their use (Asuni, 1979), doing so because they are convinced by the effectiveness of their treatment. A dilemma for these health care practitioners is the fact that the systems have not been formally integrated and therefore using both may cause a psychological dilemma or cognitive dissonance for users.

Compounding the problem in some areas is the ‘tolerant approach’ that modern medicine and governments adopt in their relationship to traditional healing (Tabuti et al., 2003). Traditional healers are not officially recognised but can apply their trade as long as

they do not aspire to be registered as doctors (Bodeker, 1995). This is a dilemma for those health care practitioners who believe in traditional healing, as they would not know what to do if they believe that a patient could be treated better by a traditional healer. This remains a conundrum that needs to be unraveled by governments, traditional healer organisations, health professions councils and other interested bodies.

3.9 CONCLUSION

Illnesses such as Aids, malaria, cholera, tuberculosis and childhood diarrhea are rampant on the African continent. South Africa's HIV infection rate remains one of the highest in the world and the battle with the illness is continuing. The Western healing system is overloaded and apparently inadequate to deal with many illnesses because of lack of health care personnel and medical resources. For some illnesses that are considered cultural in nature, the majority of Africans prefer traditional healing rather than the Western healing system because of its holistic approach, the effectiveness of its herbal remedies and its cultural relevance and cultural sensitivity. Some Africans would prefer the integration of the two health care systems so that they could have easy access to both without facing a dilemma of having to use one without the knowledge of the other, a dilemma that can have serious consequences because of problems with medication interaction and side-effects.

International health care organisations such as the WHO are in favour of collaboration between traditional and Western healing at the more formal level, despite the many criticisms leveled against traditional healing. There are a number of barriers to such integration. Some objections to integration are raised purely on religious grounds, prestige and from an economic competition point of view. Some of the criticisms seem valid and include the question of unhygienic practices by traditional healers which pose serious health risks especially in the era of Aids.

Nonetheless, collaboration between traditional healing and Western healing is proving successful in some African countries. In these countries, health care professionals' perceptions and attitudes towards traditional healing are favourable. This can serve as a lesson for South Africa in its research into the integration of the two health care systems.

To integrate the two systems successfully, health care practitioners' opinions of, attitudes towards, knowledge of and experiences with traditional healing need to be investigated. There are some studies into the perceptions and attitudes of health care practitioners, but there is still a gap in the literature in terms of health care practitioners' knowledge of, experiences with and, more importantly, preparedness to work with traditional healers. The following chapter attempts to bridge that gap by describing a study of health care practitioners' preparedness to work with traditional healers. The chapter describes the participants, the research design, data collection techniques, the statement on ethics and the procedure followed in collecting data as well as appropriate data treatment and data analysis techniques.

CHAPTER FOUR
METHODOLOGY

4.1 INTRODUCTION

This chapter gives a detailed description of the research procedure, data collection techniques and quality control measures, demographics of the participants, research design, measuring instruments as well as the statement on ethics.

4.2 RESEARCH AIMS

The study aimed to determine Western-trained health care practitioners' (i.e. psychiatrists, physicians, general nurses and psychiatric nurses) opinions of, attitudes towards, knowledge of and experiences with traditional African healing and to investigate how these factors impact on the practitioners' intentions to make use of the services of traditional African healers in the future. The study also investigated the health care practitioners' demographic data to determine if there were differences between groups in terms of their opinions, attitudes, knowledge, experiences and intentions to work with traditional healers in the future.

4.3 RESEARCH PROCEDURE

As mentioned in Chapter One, the present study was informed by the South African National Department of Health's proposed integration of the traditional African and the Western-orientated healing systems. Participants in the study were therefore sampled from State hospitals around the Johannesburg and Krugersdorp areas in Gauteng province as well as from State hospitals, clinics and one health centre in the greater Sekhukhuneland and Lepelle-Nkumpi district of Limpopo province.

Since the current research was conducted in State-owned hospitals and clinics, permission was sought from relevant State authorities. In Gauteng province, the researcher sought permission from the Chief Executive Officer (CEO) and/or the clinical manager at each targeted health care institution. In some cases, the researcher had to seek permission

through the Chief Communications Officer at the hospital. The purpose and nature of the study was fully explained to the respective authorities at each targeted health care institution. Each institution then convened a committee of experts to look at the proposed study; and then granted permission (see Appendix A). In some institutions, 'tacit' permission (see Appendix B) was granted but data could not be collected immediately as the research was put on a waiting list because of 'congestion' regarding data collection at those institutions. Some of the targeted institutions in Gauteng province were omitted because authorities would not say whether permission was granted or not. Numerous e-mails and phone calls from the principal researcher to these hospitals went unanswered.

In Limpopo province, permission to conduct the study was obtained from the office of the provincial Head of Department of Health and Social Development (see Appendix C). The principal researcher then went to each targeted institution to speak personally with each Chief Executive Officer (CEO) and with each clinical manager. In one case, the principal researcher was referred to the district health manager for permission, in addition to the permission from the provincial Head of Department. The district health manager then communicated with the targeted clinics and informed them that the study could proceed. Communication between the principal researcher and the district health manager was telephonic, and permission to go ahead with data collection was also granted telephonically, on 8 March 2011. In cases where hospital CEOs, acting CEOs and clinical managers could not be found during the visits by the principal researcher, the 'caretakers', as the staff who are temporarily in charge of hospitals or clinics in the absence of the CEOs are commonly called, were contacted and the CEOs and clinical managers subsequently spoken to telephonically as suggested by the caretakers. In all cases except for the district health manager, permission to conduct the study was granted to the principal researcher in written (see Appendix C) and verbal form.

In each targeted health care institution, the principal researcher employed a research assistant (RA) whose task was to distribute questionnaires and collect them after they had been completed. Each research assistant was trained by the principal researcher on how to approach prospective participants as well as on how to collect data. Each research assistant collected data in the hospital or clinic where he or she worked. Distribution and collection of completed questionnaires were done when the research assistant was off duty so that data collection would not interfere with their regular duties at the hospitals and clinics.

Participants were approached during working hours in their respective health care institutions. In some cases, doctors were approached during one of their regular morning staff meetings. In such cases, they were asked to take part in the study by research assistants with the permission and assistance of the clinical manager or his or her assistant in that particular health care institution. Nurses were approached either in the wards in which they were working or during one of their regular staff meetings. They were approached with the permission and assistance of the nursing manager in each health care institution.

All participants were given questionnaires to complete in their own time so that there would not be any disruptions to the daily duties of participants at health care institutions. The turn-around time for questionnaire completion and return was two to three weeks. The covering letter (see Appendix D) of each questionnaire contained information about who the principal researcher was and, without revealing the hypotheses of the study, what the research was about. The letter assured participants that their participation was voluntary and that their responses would remain anonymous. Participants were also made aware that they could refuse to participate and that they could pull out of the study whenever they felt that they did not want to continue to be part of it. This message was communicated to the participants verbally by the research assistants and in the form of a covering letter. Participants were also given details of how to contact the principal researcher if they had anything related to the research that needed clarification. The principal researcher ensured that all research assistants and research participants were unaware of the research hypotheses (Cone & Foster, 1993).

The current sample should be seen as a convenient sample, as it was based on who was on duty when the questionnaires were distributed. In some instances, research assistants tried to balance out how to distribute questionnaires by making sure that questionnaires were distributed equitably in different hospital wards, to cater for different categories of nurses.

In total, five hundred questionnaires (N=500) were distributed among psychiatrists, physicians, general nurses and psychiatric nurses between January and the end of September 2011. Out of the 500 questionnaires distributed, three hundred and nineteen (n=319) were correctly completed and returned, a 63.8% return rate. The characteristics of the participants are discussed in Section 4.4.

To prevent a situation where data would be collected from health care practitioners other than the categories targeted by the study, the principal researcher adopted a hands-on approach for quality control purposes, as discussed below.

4.3.1 Data collection quality control measures

For quality control purposes, the principal researcher occasionally had a telephonic conversation with hospital clinical managers to check if data collection was taking place and whether suitable categories of health care practitioners were being targeted. In addition, the principal researcher had similar conversations with the research assistants. For further quality control, the principal researcher physically visited participating hospitals and clinics immediately after data collection and spoke to three or four health care practitioners. These were chosen randomly as the researcher made rounds at the participating health care institution. In addition, the principal researcher spoke with one senior manager such as a nursing manager in each institution to establish if they had heard about the study taking place in their respective health care institutions. This was done without asking those health care practitioners whether they had participated or not. All of them indicated that they knew that the study was being conducted or had just been conducted at their institution. On average, except for the conversation between principal researcher and each nursing manager or clinical manager which lasted longer, each conversation lasted for just over two minutes. This exercise was time consuming but was deemed necessary to make sure that the data were indeed collected at the targeted health care institutions. Hospital CEOs, clinical managers and nursing managers were verbally thanked for allowing and assisting in data collection at their respective institutions.

4.3.2 Housing for the final product (the thesis)

As per University of South Africa (UNISA) regulations regarding post graduate theses and dissertations, this thesis remains the property of the university. However, as per requirement, protocol and agreement with the Limpopo provincial Department of Health and Social Development, where part of the study was conducted, a copy of the thesis will be housed within the Department for future references. Regarding participating hospitals in Gauteng

province, no agreement was entered into between the principal researcher and the participating hospitals regarding the housing of the thesis.

4.4 RESEARCH PARTICIPANTS

The sample consisted of health care practitioners working in rural and urban hospitals and clinics in two provinces in South Africa: Limpopo and Gauteng. All participants were able to read, understand and speak English and in that respect filling in questionnaires presented no problems. All questionnaires were written in English, and translation of questionnaires into other languages was therefore unnecessary.

All psychiatrists, physicians, general nurses and psychiatric nurses could participate in the current study. No restrictions were placed on prospective participants on the basis of their gender, race, language and religious classification, and the sample was demographically diverse. After data were collated from 319 participants, descriptive statistics to determine frequency distributions of participants was computed using IBM SPSS version 19. Descriptive statistics results revealed that the majority of the participants were female (72.4%; n = 231), and 27.6% (n = 88) were male. Their mean age was 39.8 years with a Standard Deviation of 11.1 years. The youngest participant was 21 years old while the oldest participant was 72 years old. The mean/average time, in years, that participants had been in their designated roles, as physicians, nurses and so on, was 9.97 years with a Standard Deviation of 9.49 years. The participant with the shortest service in years was 1 year in designated role while the participant with the longest service was 46 years in designated role.

Regarding home language distributions, the sample was made up of more Sepedi speaking participants than any other home language speakers, with just over forty six percent (46.7%; n = 149) of participants reporting speaking Sepedi as their home language. The second largest group (9.7%, n = 31) reported speaking isiZulu as their home language. The smallest group (1.6%; n = 5) indicated that isiSwati was their home language (see Figure 4.1 below). Participants who were classified as ‘other’ (2.8%, n = 9) had a language foreign to South Africa as their home language.

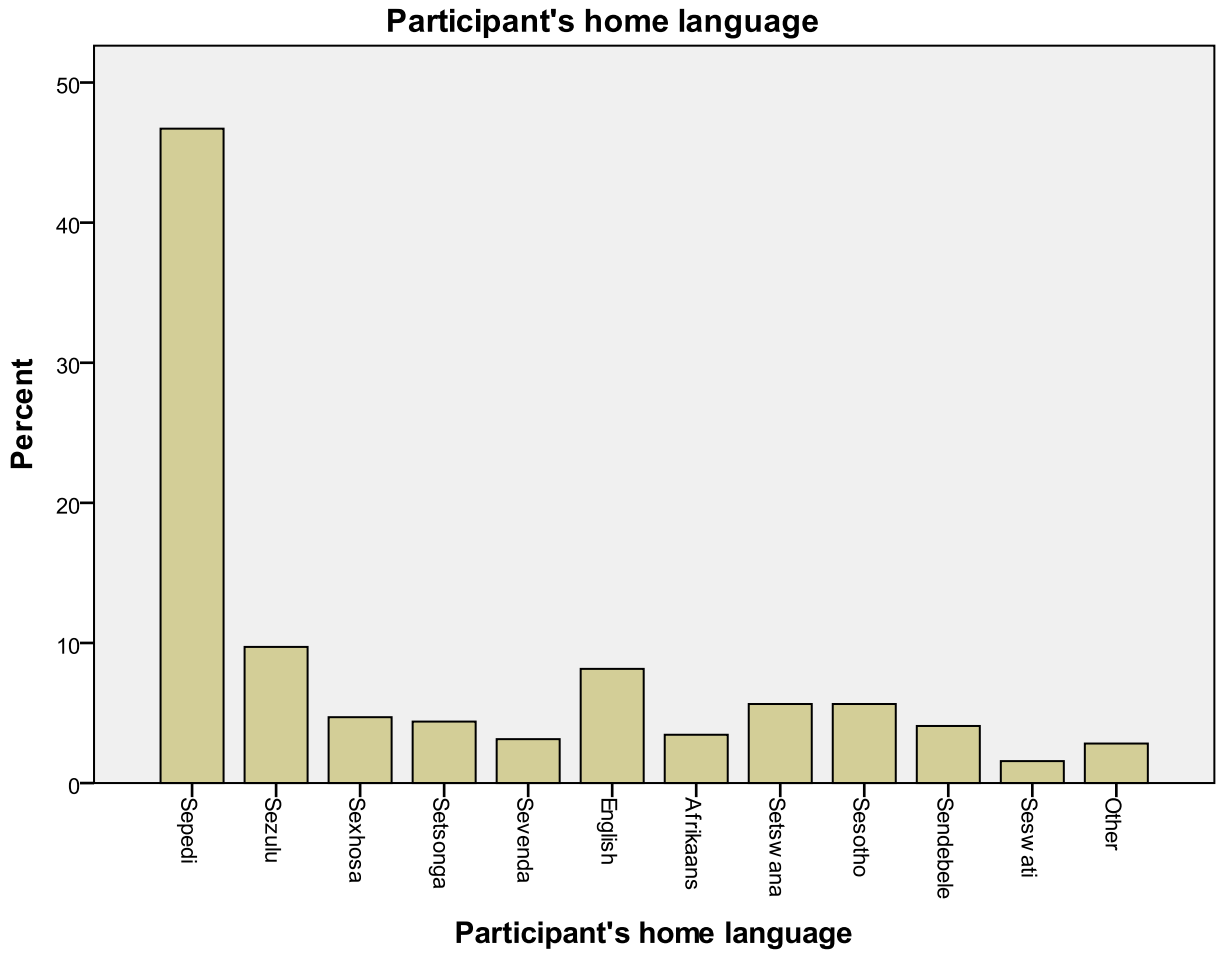

Figure 4.1 Percentage distribution according to participants' home language (N=319)

Religion and traditional African healing are closely linked (Chavunduka, n.d.) and for that reason, the study classified participants according to religion. In the South African context, religious categorisation is complex. Some religious practices or religious convictions are interconnected and people practicing those religions are at times difficult to classify under one or the other religion. The line dividing between some religious classifications is thin and blurred. However, an attempt has been made to categorise the participants according to their religious beliefs (see Figure 4.2).

The Christian religion formed the largest group (70.8%; n = 226), with participants who believed only in traditional African religion forming the smallest group (0.9%; n = 3). Ten percent of participants (n = 32) believed in both Christianity and traditional African religion concurrently, while 12.5% (n = 40) belonged to African Independent Christian churches which tend to incorporate African traditions and customs in their practice of

Christianity. A small percentage (4.1%; n = 13) of participants indicated that they were not religious (see Figure 4.2). Out of the thirteen participants who indicated that they were not religious, two participants went further to indicate that they were once religious because of their upbringing but that they are no longer religious.

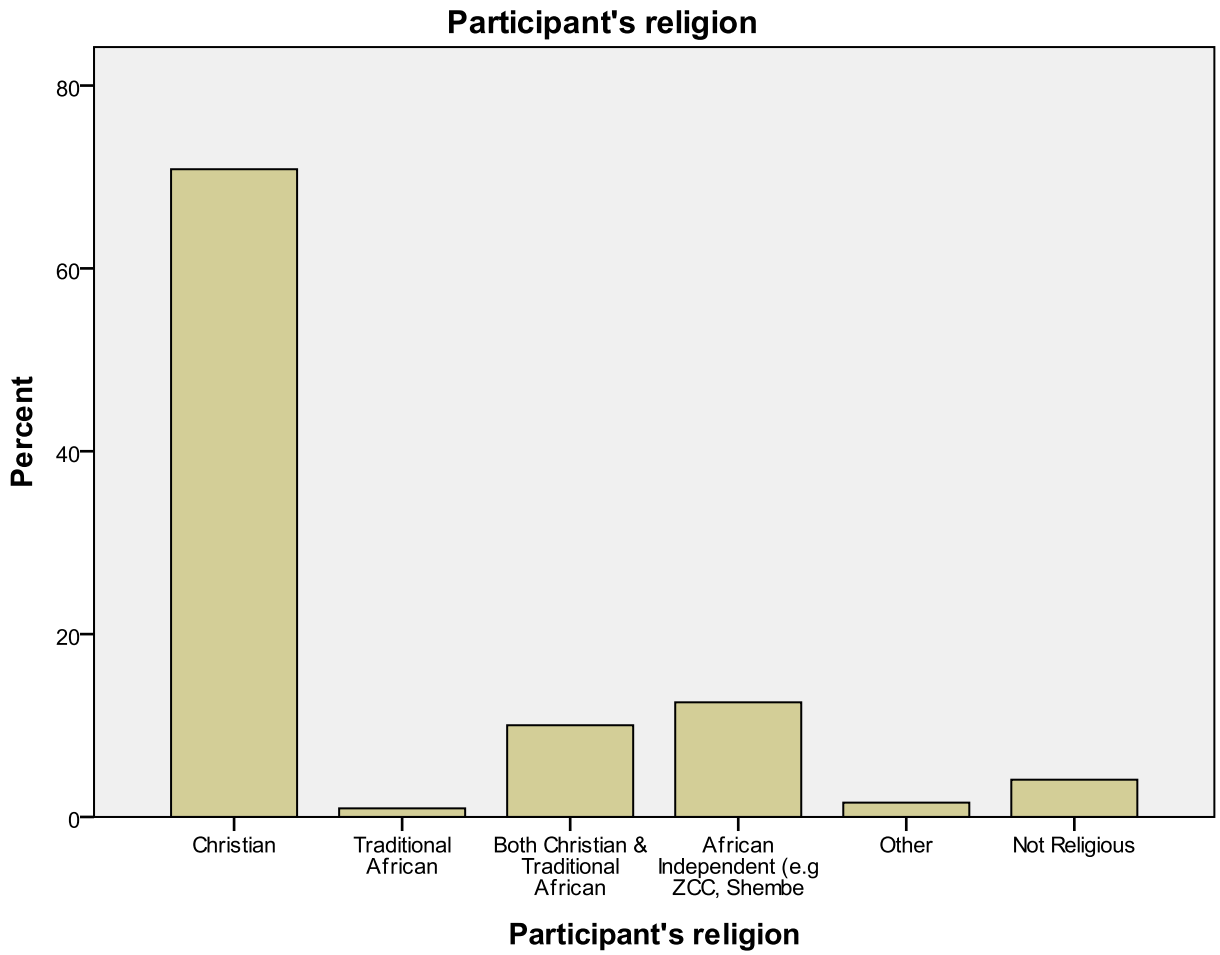

Figure 4.2 Percentage distributions according to participants' religious beliefs (N = 319)

Participant's designated role in the health care institution where they worked formed the main classification, owing to the hypotheses, in the study. The largest percentage of the 319 health care practitioners who participated were general nurses (52.7%; n = 168), while psychiatrists (7.8%; n = 25) expectedly yielded the lowest percentage of participants since they are one of the minority categories in the health care sector and there is a shortage of personnel in this category. Just over eleven percent (11.6%; n = 37) of participants were

physicians while 27.9% (n = 89) were psychiatric nurses. Figure 4.3 presents the percentage distributions of participants in each of the four categories of health care practitioners in the study.

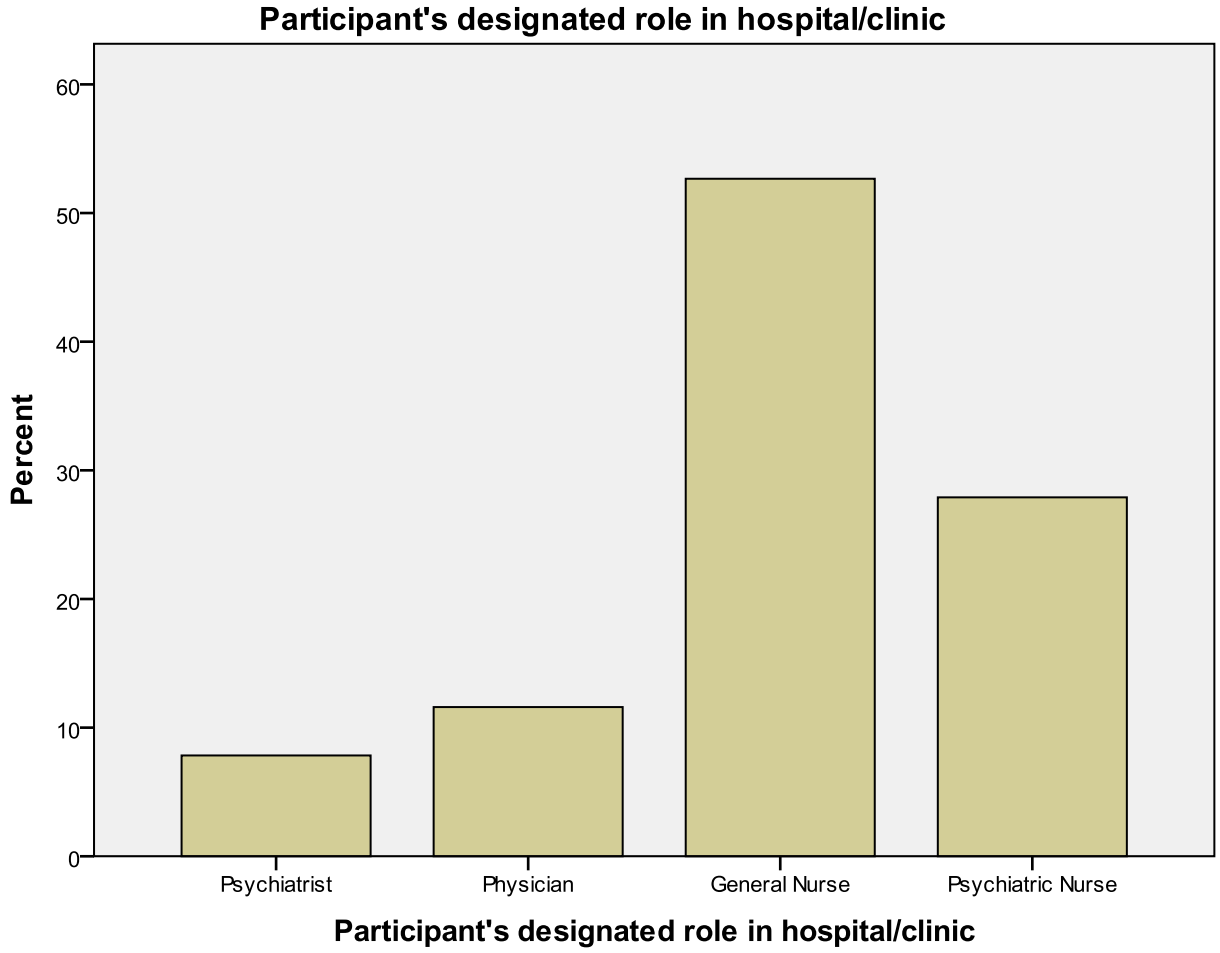

Figure 4.3 Percentage distributions according to participants' designated role within the health care institution where they worked (N = 319)

Lastly, participants were categorised according to the area or setting in which they worked as health care practitioners. The majority (68%; n = 217) were working in State hospitals and or clinics in rural areas. All of these rural areas were in Limpopo province, in the north of South Africa. Almost a third (32%; n = 102) were working in urban areas of Gauteng province (see figure 4.4).

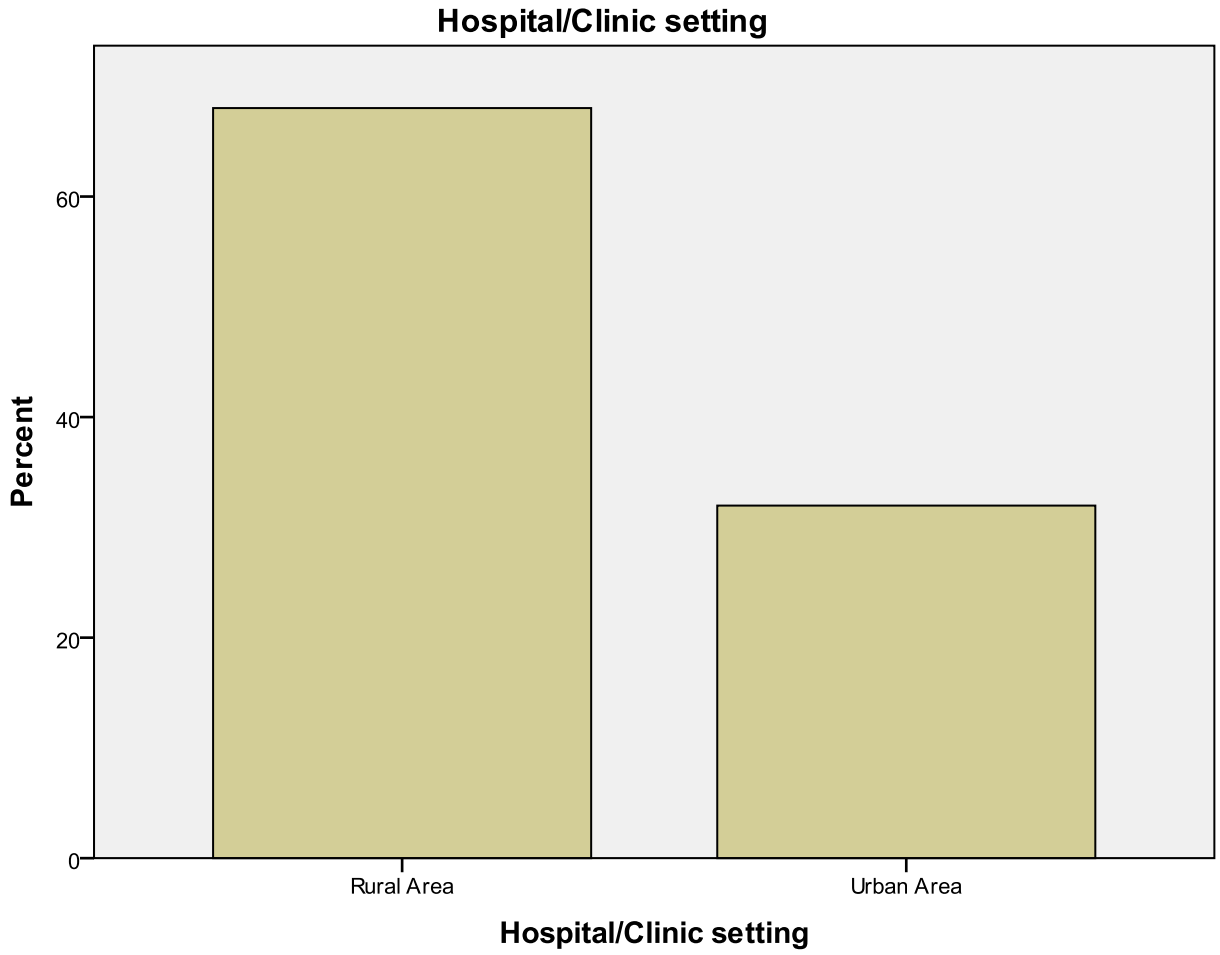

Figure 4.4 Percentage distributions according to area/setting in which participants worked (rural or urban) (N = 319)

4.5 RESEARCH DESIGN

There has long been a battle between quantitative and qualitative research designs in psychosocial research. Some researchers would only opt to obtain answers to research questions quantitatively by using statistics. Quantitative techniques are regarded as objective and therefore scientific, and studies that employ these kinds of techniques can easily be replicated by different researchers. Qualitative studies have been criticised as unscientific and therefore less reliable, with qualitative research being objected to by the mainstream of social sciences (Kvale, 1994). According to Kvale, these objections may vary from technical issues such as of the fact that qualitative research findings sometimes result from interviewers inadvertently asking leading questions to epistemological issues that question the objectivity of knowledge created through qualitative research methods.

The above critique could be valid particularly if the interviewer and the person analysing the interview responses are not well-trained in such techniques. However, if used appropriately, qualitative techniques can be an important tool yielding data that may even surpass in value responses that are merely reduced to numbers, as might be the case in some quantitative techniques. Moreover, data obtained through qualitative techniques can influence further research using quantitative techniques. Qualitative and quantitative techniques tend to complement each other and therefore their joint use is often encouraged, depending on the question that the researcher is attempting to answer (Mingers, 2001). Psychosocial researchers can collect a wealth of data and yield invaluable results if the two techniques are used concurrently, depending on the research question to be answered.

The present study employed a **Within-Stage Mixed Model design** (Johnson & Onwuegbuzie, 2004). This design combines elements of both the quantitative and qualitative techniques. When combining these elements, it is up to the researcher to decide where the mixing of the models should take place; it could do so at the research objectives stage, the data collection stage, the data analysis stage or at the data interpretation stage. In the current study, the mixing of the models took place at three stages namely the data collection, data analysis and data interpretation stages. At the data collection stage, a Within-Stage Mixed Model design employs a Likert-type quantitative questionnaire that includes some open-ended items. The combination of closed-ended and open-ended questions in a single questionnaire is done without necessarily compromising the flow of questions and responses. Responses from the open-ended items are intended to supplement, further clarify or elaborate on responses given on the closed-ended items (Johnson & Onwuegbuzie, 2004). At the data analysis and interpretation stages, the words that participants use in response to qualitative questions can be used to clarify their quantitative responses. The addition of words during data analysis and interpretation stages can be in the form of narratives or themes. The current study chose to use participants' narratives in both the data analysis and interpretation stages.

In this study, each open-ended item was carefully crafted to be the sequel of the item that immediately preceded it. For example, item number 53 stated that "*There are psychiatric conditions that can be treated by traditional healers*" (see Appendix E). Participants were asked to indicate whether they *(1) strongly agreed; (2) agreed; (3) were not sure; (4) disagreed; or (5) strongly disagreed* with the statement. The statement that immediately followed that (i.e. item 54) stated that " *If you strongly agreed or agreed with the statement*

above, please mention any psychiatric conditions that you know can be treated by traditional healers". In that way, participants did not lose focus and the open-ended questions did not interfere with the smooth flow of responding to quantitative items in the questionnaire.

When employing a Within-Stage Mixed Model design, a researcher has an option to make one model dominant over the other. In the current study, the researcher chose to make the quantitative model the dominant one. In other words, the qualitative responses were used to supplement the quantitative responses and not the other way round.

4.6 MEASURING INSTRUMENTS

This study utilised the Views on Traditional Healing Questionnaire (hereafter referred to as the VTHQ) designed for the current study by the principal researcher (see Appendix E). The VTHQ was designed to measure health care practitioners' opinions of, attitudes towards, knowledge of and experiences with traditional healing as well as their behavioural intentions of working with or utilising the services of traditional healers in the future. The VTHQ consisted of 90 closed-ended questions (i.e. quantitative items) and seven open-ended questions (i.e. qualitative items), a total of 97 questions. Participants were requested to read the questionnaire statements and indicate on a 5-point Likert-type scale to what extent they agreed, disagreed or had experienced the views suggested by the statements; the questionnaire items and scales are discussed in detail in section 4.6.1. In some cases, participants were given the opportunity to elaborate on their choices by answering an open-ended question. That was done in cases where participants either strongly agreed or agreed with the statement.

The questionnaire consisted of the following four parts:

- **Part 1** asked participants about their demographic characteristics such as gender, age, home language, religion, designated role in the hospital/clinic where they work, number of years in the designated role as well as whether their place of work was in rural or urban areas.

- **Part 2** contained 69 questions/items about the participants' opinions of, attitudes towards and knowledge of traditional African healing.

- **Part 3** contained 15 statements and questions to measure the participants' experiences with traditional African healing.

- **Part 4** contained 13 questions to measure participants' intentions to work with traditional healers in the future.

Before data collection, the VTHQ was given to ten individuals who had expertise in questionnaire construction. The group comprised of academics in the fields of health sciences and social sciences as well as those who were working as nurses and doctors. As a result of their feedback, the wording of some items as well as the order of their appearance in the questionnaire was changed. In addition, the demographic data part (i.e. Part 1) of the questionnaire was given to an expert in demographics for her critique. The questionnaire was then piloted with twenty-five health care practitioners to determine if it would work well in the field. After analysing the data from the pilot study, no changes were found necessary and the data from the pilot study were included in the final analysis.

4.6.1 Principal Component Analysis (PCA)

The 90 closed-ended items on the VTHQ (i.e. Parts 2, 3 and 4 of the questionnaire) were subjected to Principal Component Analysis (PCA) using IBM SPSS version 19 to refine the items into coherent sub-scales. The suitability of the VTHQ's data for factor analysis was assessed prior to performing the PCA. The sample size was large enough (N= 319) to render the data factorable (Pallant, 2010). In addition, the Kaiser-Meyer-Olkin Measure of Sampling Adequacy for the current sample indicated a value of 0.927 which far exceeded the recommended value of 0.6 (Brace, Kemp & Snelgar, 2003). This value also attested to the construct validity of the VTHQ questionnaire utilised in the study. Bartlett's test of sphericity also revealed a significant value and therefore indicated that the VTHQ was factorable with $p < 0.001$.

After studying the results of the Principal Component Analysis, it was decided to retain 68 of the original 97 items to form the VTHQ scale. Five factors with eigenvalues greater than two (i.e. eigenvalue > 2) were extracted. An inspection of the scree plot also indicated a five factor solution (see Appendix F). Interpretation of the five components was

based on how strongly the variables loaded on each component (after varimax rotation was performed) as well as the content of the variables that were clustered together by the PCA.

The five factors explained a total of 42.9% of the variance of Western-trained health care practitioners' views on traditional African healing. The contribution of each one of the components was as follows:

- Component 1 consisted of 22 items, accounting for 28.4% of the variance and was interpreted as **Attitudes** (eigenvalue = 25.5);
- Component 2 consisted of 19 items, accounting for 4.6% of the variance and was termed **Opinions** (eigenvalue = 4.2);
- Component 3 consisted of 10 items, accounting for 4.2% of the variance and was called **Experiences** (eigenvalue = 3.8);
- Component 4 consisted of 7 items, accounting for 2.9% of the variance and was called **Behavioural Intentions** (eigenvalue = 2.6);
- Component 5 consisted of 10 items, accounting for 2.8% of the variance and was interpreted as **Knowledge** (eigenvalue = 2.5).

Table 4.1 below presents the items of the VTHQ as well as their loadings on the five aforementioned components as determined by the Principal Components Analysis. The notations in brackets (e.g. P2/I26) denote the parts and item numbers in the questionnaire. For example, P2 stands for Part 2 and I26 in this case stands for item number 26 of Part 2 in the questionnaire.

Table 4.1 Component loadings on the Views on Traditional Healing Questionnaire

Item	Att	Opi	Exp	Int	Kno
Would support integration of TH & WH (P2/I26)	.708				
I do not want to learn anything about TH (P2/I20)	.708				
I would not encourage anybody to use TH (P2/I13)	.696				
WHC & THC could improve health if worked together (P2/I12)	.694				
Would collaborate with TH in treating patients (P2/I22)	.688				
Would never use TH for any reason (P2/I15)	.682				
TH should continue to be separate from WH (P2/I8)	.674				
If proper regulation of TH, TH would be a good system (P2/I18)	.673				
TH important for maintenance of health (P2/I7)	.667				
TH cannot be trusted (P2/I10)	.651				
Government is doing well by supporting TH (P2/I29)	.645				
Would consider referring patients to TH (P2/I30)	.639				
TH should be discarded (P2/I23)	.639				
When people ill, should see W-doctors & not TH (P2/I19)	.629				
Integration of TH & WH will not work (P2/I4)	.613				
I want to learn more about TH (P2/I1)	.594				
Would consider consulting TH in the future (P2/I9)	.589				
TH is dangerous (P2/I36)	.573				
When ill, I consider both TH & WH (P2/I11)	.543				
TH belongs in the olden days (P2/I2)	.521				
Would seek help from TH even when W medicine available (P2/I35)	.520				
Medical aid schemes should not recognise TH (P2/I6)	.399				

Table 4.1 Component loadings on the Views on Traditional Healing Questionnaire (continued)

Item	Att	Opi	Exp	Int	Kno
TH in South Africa is well regulated (P2/I32)		.675			
Training of traditional healers is adequate (P2/I31)		.626			
TH effective in treating psych. conditions e.g. schizophrenia (P2/I28)		.625			
THs be allowed to issue medical certificates to patients (P2/I33)		.601			
TH can effectively treat psych. conditions just like WH does (P2/I24)		.573			
TH effective in treating physio-conditions e.g. epilepsy (P2/I27)		.557			
There are psych conditions that can be treated by THs (P2/I53)		.532			
I am satisfied with the way TH works (P2/I68)		.512			
The WHO encourages TH as a primary HC system (P2/I38)		.502			
THs should be formally recognised by HPCSA (P2/I34)		.496			
TH is more holistic in its approach than WH (P2/I49)		.464			
There are physio-conditions that can be treated by TH (P2/I51)		.452			
TH is safe to use (P2/I21)		.442			
In SA, there are hospitals/clinics that collaborate with THs (P2/I39)		.415			
TH has important role to play in South Africa (P2/I37)		.386			
TH is part of people's culture & should be encouraged (P2/I17)		.383			
THs are important primary HC providers (P2/I64)		.382			
TH is an acceptable system (P2/I25)		.376			
TH is a good primary HC system (P2/I5)		.360			
I have consulted THs after qualified as HC practitioner (P3/I4)			-.678		
I have consulted THs before qualified as HC practitioner (P3/I3)			-.614		
I have seen patients effectively treated by THs (P3/I13)			-.508		
I do refer patients to THs (P3/I8)			-.481		
I often consult THs (P3/I1)			-.475		
Some of my friends consult THs (P3/I5)			-.471		

Table 4.1 Component loadings on the Views on Traditional Healing Questionnaire (continued)

Item	Att	Opi	Exp	Int	Kno
WHC practtioners consult THs for reasons other than illness (P3/I15)			-.461		
THs often share knowledge of HC with me (P3/I9)			-.449		
Heard of W-trained HC practitioners consult THs when ill (P3/I14)			-.421		
I have treated patients who were referred by THs (P3/I7)			-.381		
I would like to attend joint workshops with THs (P4/I10)				.587	
I would like to share knowledge about hygiene with THs (P4/I9)				.582	
Prepared to visit THs rooms to observe THs work (P4/I12)				.542	
Would only collaborate with THs if properly regulated (P4/I11)				.454	
Would encourage other HC practitioners to learn about TH (P4/I8)				.408	
Prepared to support integration of TH with WH (P4/I13)				.365	
Prepared to work with traditional birth attendant (P4/I6)				.355	
There are some Christians who consult THs (P2/I41)					.601
In TH there are illnesses believed to be inflicted by ancestors (P2/I45)					.564
±80% of blacks in South Africa use services of THs (P2/I42)					.515
Some THs are Christians (P2/I47)					.486
TH uses animal, plant products & mineral substances (P2/I43)					.431
In TH, cultural, physical & spiritual data used for diagnosis (P2/I44)					.387
TH is accepted by my community (P2/I60)					.383
In TH some illnesses believed to be caused by witchcraft (P2/I46)					.375
TH is here to stay (P2/I3)					.357
Ancestral spirits are pillars of TH (P2/I48)					.325

Table 4.1 Component loadings on the Views on Traditional Healing Questionnaire (continued)

Item	Att	Opi	Exp	Int	Kno
Eigenvalues	25.512	4.153	3.794	2.617	2.478
Percent variance	28.346	4.615	4.215	2.908	2.753

Abbreviations: P2/I26: Part 2/Item 26; **Att**: Attitudes; **Opi**: Opinions; **Exp**: Experiences; **Int**: Intentions; **Kno**: Knowledge; **TH**: Traditional healing; **THs**: Traditional healers; **WH**: Western healing; **HC**: Health care; **WHC**: Western health care; **THC**: Traditional health care

Total variance explained: 42.8%

Extraction method: Principal Component Analysis

Rotation method: Varimax with Kaiser Normalization

The following sub-sections discuss characteristics of each sub-scale (component) of the VTHQ which include the internal reliabilities of each sub-scale. To add up the total scores for each sub-scale, all items for each sub-scale were totalled and then divided by the number of items in the sub-scale. For example, for the Attitudes sub-scale the total attitudes score was divided by 22 (because there were 22 items that made up the Attitudes sub-scale). The same procedure was used for the Opinions, Experiences, Behavioral Intentions and Knowledge sub-scales. Therefore, the minimum and maximum possible values for each participant would respectively be 1 and 5 for each sub-scale. The advantage of using this procedure is that it makes interpretation of total scale scores relatively easy because it is back in the original scale used for each scale item (e.g. from 1 to 5 representing strongly agree to strongly disagree) (Pallant, 2010).

4.6.1.1 The Attitudes sub-scale

Health care practitioners' attitudes towards traditional healing were measured on the Attitudes sub-scale which was made up of 22 items. The 22 items which formed the Attitudes sub-scale were all in Part 2 of the VTHQ and included items 1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 13, 15, 18, 19, 20, 22, 23, 26, 29, 30, 35 and 36. Examples of items measuring attitudes are as

follows: "*I want to learn more about traditional healing*" (Item 1), and "*Traditional healing is dangerous*" (Item 36). Items 2, 4, 6, 8, 10, 13, 15, 19, 20, 23 and 36 were reverse-scored as they were negatively worded.

The Attitudes sub-scale was modeled on the Likert-type scale in which participants were asked to tick one box only on the scale of 1 to 5 (*1 = strongly agree; 2 = agree; 3 = not sure; 4 = disagree; and 5 = strongly disagree*). The range of the scale was between 1 and 5. High scores indicated positive attitudes while low scores indicated negative attitudes towards traditional healing.

The Attitudes sub-scale was subjected to reliability analyses and yielded the following internal reliability values: Cronbach's alpha coefficient was high at 0.95, Spearman-Brown coefficient was also high at 0.94 and Guttman Split-Half coefficient was almost equally high at 0.93.

4.6.1.2 The Opinions sub-scale

The Opinions sub-scale was a 19-item scale measuring opinions on the Likert-type scale of 1-5 (*1 =strongly agree; 2 = agree; 3 = not sure; 4 = disagree; and 5 = strongly disagree*). The range of the scale was between 1 and 5. High scores indicated positive opinions while low scores indicated negative opinions of traditional healing. The Opinions sub-scale was made up of items number 5, 17, 21, 24, 25, 27, 28, 31, 32, 33, 34, 37, 38, 39, 49, 51, 53, 64 and 68. All these items were in Part 2 of the VTHQ. Examples of items measuring opinions are as follows: "*Traditional healing is a good primary health care system*" (Item 5) and "*I am satisfied with the way traditional healing works*" (Item 68). No item was reverse-scored.

In the current study, the Opinions sub-scale showed a high Cronbach's alpha coefficient of 0.93, Spearman-Brown coefficient was 0.92 and Guttman Split-Half coefficient was also 0.92.

4.6.1.3 The Experiences sub-scale

Experiences with traditional healing were measured on the Experiences sub-scale which consisted of 10 items that were modeled on the Likert-type scale of 1-5 (*1 = never; 2 =*

seldom; 3 = often; 4 = regularly; 5 = always). The range of the scale was between 1 and 5. High scores indicated more experience while low scores indicated less experience with traditional healing. This sub-scale comprised of items 1, 3, 4, 5, 7, 8, 9, 13, 14 and 15 which were in Part 3 of the VTHQ. Examples of items measuring experiences are as follows: "*How often do you consult a traditional healer*"? (Item 1) and "*I have heard of Western-trained health care practitioners who consult traditional healers for reasons other than illness"* (Item 15). No item was reverse-scored.

For the Experiences sub-scale, Cronbach's alpha coefficient was moderately high at 0.76, Spearman-Brown Coefficient was 0.75 and Guttman Split-Half coefficient was 0.75.

4.6.1.4 The Behavioural Intentions sub-scale

Health care practitioners' behavioural intentions were measured on a 7-item Likert- type scale of 1-5 (*1 = absolutely; 2 = maybe; 3 = unsure; 4 =not likely; 5 = not at all*). The following items in Part 4 of the VTHQ formed the Behavioural Intentions sub-scale: 6, 8, 9, 10, 11, 12 and 13. Examples of items measuring behavioural intentions are as follows: "*I am prepared to work with a traditional birth attendant*" (Item 6) and "*I am prepared to support the integration of traditional healing with Western medicine*" (Item 13). No item was reverse-scored. The range of the scale was between 1 and 5. High scores indicated that health care practitioners were willing to work with traditional healers in the future. Low scores suggested that health care practitioners were either reluctant or not willing to work with traditional healers in the future.

For the Behavioural Intentions sub-scale, Cronbach's alpha coefficient was high at 0.87, Spearman-Brown coefficient was 0.89 and Guttman Split-Half coefficient was 0.88.

4.6.1.5 The Knowledge sub-scale

Health care practitioners' knowledge of traditional healing was measured on the Knowledge sub-scale. The Knowledge sub-scale was made up of 10 items modeled on the Likert-type scale of 1-5 (*1 = strongly agree; 2 = agree; 3 = not sure; 4 = disagree; 5 = strongly disagree*). This sub-scale was made up of items in Part 2 of the VTHQ which included items

3, 41, 42, 43, 44, 45, 46, 47, 48, and 60. Examples of items measuring knowledge are as follows: "*Some traditional healers are Christians*" (Item 47) and "*Ancestral spirits are pillars of traditional healing*" (Item 48). No item was reverse-scored. The range of the scale was between 1 and 5. High scores indicated more knowledge of traditional healing while low scores indicated less knowledge of traditional healing.

For the Knowledge sub-scale, Cronbach's alpha was 0.81, Spearman-Brown coefficient was 0.78 and Guttman Split-Half coefficient was 0.78.

4.7 VALIDITY OF THE VIEWS ON TRADITIONAL HEALING QUESTIONNAIRE

To determine construct validity, each construct's items were aggregated to determine the best fit by a five component Maximum Likelihood rotation method of Promax with Kaiser Normalisation rotations. Further similarity matrix between sub-scales of the VTHQ revealed that the sub-scales were all different, suggesting that they measured different psychological constructs. Inter-item correlations for each sub-scale were positive suggesting that items within each sub-scale measured the same construct.

Concurrent validity of the VTHQ could not be determined as the researcher could not find similar quantitative scales that measured the variables that were measured by the VTHQ. Previous research that looked at health care practitioners' opinions, attitudes, experiences and perhaps knowledge of traditional healing tended to employ qualitative techniques and not quantitative techniques.

4.8 ETHICAL CONSIDERATIONS

Ethics clearance for the current study was obtained from the Ethics Committee of UNISA's Department of Psychology. In all participating health care institutions, data was collected according to the protocol agreed upon between the principal researcher and the institution concerned (in some instances, the area manager). No financial rewards were offered to participants in this study. However, research assistants, none of whom was a respondent in this study, were offered a stipend calculated in accordance with the number of correctly completed and returned questionnaires.

Each distributed questionnaire had a covering letter (see Appendix D) that explained what the study was about. A signed informed consent form was deemed unnecessary as data were collected through anonymous questionnaires in which participants' confidentiality was protected. This practice of dispensing with signed informed consent is permissible in social-psychological research wherein participants are not subjected to any harm whatsoever (Gravetter & Forzano, 2009).

4.9 DATA ANALYSES AND STATISTICAL PROCEDURES

The following sub-sections deal with the data analysis techniques employed in the study. The first sub-section describes the quantitative techniques while the second sub-section describes the qualitative techniques.

4.9.1 Quantitative data analysis

To test for differences between categories of health care practitioners (psychiatrists, physicians, general nurses and psychiatric nurses) in terms of their opinions, attitudes, knowledge, experiences and intentions to work with traditional African healers, five separate Kruskal-Wallis Tests were computed. The Mann-Whitney U post hoc tests were computed to determine where specific differences between groups were for the Opinions, Attitudes, Knowledge, Experiences and Intentions variables. The effect size for each comparison was calculated according to the following formula: **r = z / square root of N** (Pallant, 2010). It was decided to use non-parametric tests since the questionnaire was developed by the author and is thus not a standardised questionnaire. The general assumptions for computing non-parametric tests such as the Kruskal-Wallis Test and Mann-Whitney U Test were checked, and both of the assumptions (i.e. random samples as well as independent samples) were not violated. The Kruskal-Wallis and Mann-Whitney U Tests were further used to determine if there were any biographical differences in terms of health care practitioners' opinions, attitudes, knowledge, experiences and intentions to work with traditional healers in the future.

To establish if opinions, attitudes, knowledge and experiences with traditional healing contributed to health care practitioners' intentions to work with traditional healers in the future, standard multiple regression analysis was computed. Preliminary assumption testing

was conducted to check for normality, multicollinearity, singularity, linearity, homoscedasticity, homogeneity of variance-covariance matrices, independence of residuals, univariate and multivariate outliers with no serious violations observed. A few outliers were observed but the inspection of Cook's Distance (0.146 which is less than 1) indicated that those outliers did not have any undue influence on the results for the regression model as a whole (Pallant, 2010).

Collinearity statistics revealed that Opinions (0.315), Attitudes (0.311), Knowledge (0.627) and Experiences (0.760) had stronger relationship amongst each other as predictor variables. All predictor variables had tolerance values greater than 0.1(see Table 4.2). For that reason, no predictor variable was excluded from the standard multiple regression analysis.

Table 4.2 Standardised beta coefficients, part correlations, percentage variance, tolerance and VIF values for predictor variables (N = 319)

Predictor	Beta	P	Part Correlations	Unique % Variance	Tolerance	VIF
Opinions	0.168	0.018	0.094	0.9%	0.315	3.179
Attitudes	0.457	0.000	0.255	7%	0.311	3.213
Knowledge	0.175	0.001	0.138	2%	0.760	1.595
Experiences	-0.005	0.904	0.005	0.003%	0.627	1.315

4.9.2 Qualitative data analysis

Qualitative data were analysed by using participants' responses to the qualitative items to form the narratives[3]. In narrative analysis, the stories, main issues or words that research participants use provide insights about their lived experiences (Miles, 1994; Thorne, 2000). When analysing data of a qualitative nature, the researcher made sure that only data relevant

[3] NB: There were only narratives for Opinions and Knowledge of traditional healing because those were the only qualitative items that were included in the VTHQ. There were no qualitative items, and hence no narratives, for Attitudes, Experiences and Intentions to work with traditional healers.

to the study formed part of the core analysis. Data not directly part of the study but that could be linked to the study in one way or the other formed part of the recommendations for further research in this area. According to Poggenpoel (1988, as cited in Rudnick, 2002), one needs a strategy called 'bracketing' when analysing data of a qualitative nature. Bracketing is a qualitative research technique that is employed to make sure that the researcher's knowledge about the phenomenon being researched is set aside (Tufford & Newman, 2010). When employing a bracketing technique, the researcher must approach the data analysis process with an open mind so that one's biases and preconceived ideas do not ultimately influence the analysis process (Poggenpoel, 1988).

In the study, qualitative questions/items were formulated in a manner that required participants' responses to be short; in some instances a one-word response would have sufficed. This was done to supplement the responses from some of the closed-ended (quantitative) items. The short responses helped to also prevent the researcher's biases from interfering with the analysis process as the data speak for themselves, as it were. Therefore, the analysis of qualitative data for the study was relatively simple, but invaluable when combined with the results of the statistical analyses. Responses on each qualitative item were read and separately summarised, item by item, by three people including the principal researcher. There were no differences of opinion, in terms of where to classify the items between the three people who analysed the qualitative data.

4.10 CONCLUSION

In this chapter, the reader was presented with the aims of the study. The reader was also given a clear picture of who took part in this study, what was done, where was it done, how it was done and when the study was carried out. The reader was also informed about how both the quantitative and qualitative data (mixed models) were analysed to make sense of what health care practitioners had to say or think about traditional healing.

The next chapter presents detailed statistical analyses of the quantitative data as well as the narratives from the accompanying qualitative data.

CHAPTER FIVE

RESULTS: TRADITIONAL HEALING – OPINIONS, ATTITUDES, KNOWLEDGE, EXPERIENCES AND INTENTIONS

5.1 INTRODUCTION

Integrating traditional African healing and Western medicine, as South Africa proposes to do, would require a more thorough investigation of factors that might impact on the viability of that proposed integration. Some of the factors are those that the current study focused on, namely Western-trained health care practitioners' opinions, attitudes, knowledge, experiences and intentions to work with traditional healers. These factors are important because they could shed light on these practitioners' willingness, or lack thereof, to work with traditional healers in the future. Therefore, the present study aimed to explore Western-trained health care practitioners' *opinions* of, *attitudes* towards, *knowledge* of and *experiences* with traditional African healing and to further investigate how these factors impact on the practitioners' intentions to make use of the services of traditional African healers in the future. The study further investigated health care practitioners' demographic data to determine if there were differences between groups in terms of their opinions, attitudes, knowledge, experiences and intentions to work with traditional healers in the future.

This study set out to test the following hypotheses:

Hypothesis 1: There would be significant differences between the four categories of health care practitioners in terms of their *opinions* of the traditional African healing system.

Hypothesis 2: There would be significant differences between the four categories of health care practitioners in terms of their *attitudes* towards the traditional African healing system.

Hypothesis 3: There would be significant differences between the four categories of health care practitioners in terms of their *knowledge* of the traditional African healing system.

Hypothesis 4: There would be significant differences between the four categories of health care practitioners in terms of their *experiences* with traditional African healing.

Hypothesis 5: There would be significant differences between the four categories of health care practitioners in terms of their *intentions* to work with traditional healers in the future.

Hypothesis 6: A significant proportion of Western-trained health care practitioners' intentions to work with traditional African healers would be explained by their opinions, attitudes, knowledge and experiences with the traditional African healing system.

Before presenting the results of each hypothesis tested, the descriptive statistics on how Western-trained health care practitioners generally felt about traditional healers/healing will be presented. The narratives (qualitative data) will then be discussed where relevant. Finally, significant biographical differences between groups will be presented.

5.2 HEALTH CARE PRACTITIONERS' OPINIONS OF TRADITIONAL HEALING

The following sections deal with opinions of traditional healing. Both the descriptive statistics and the narratives, as advanced by the participants, are discussed.

5.2.1 Descriptive statistics

Health care practitioners in the study expressed moderate opinions about traditional healing in South Africa, with a mean of 2.68 (SD = 0.72, N = 319) on the opinion scale which ranged from 1 (negative opinions) to 5 (positive opinions) (see Table 5.1). The minimum score obtained was 1.00 and the maximum score was 4.42.

5.2.1.1Satisfaction with traditional healing

An inspection of the frequencies of the individual items revealed that 63.9% (n = 204) reported being satisfied with the way traditional healing works (see Table 5.2). Almost sixty percent (57.7%) of the health care practitioners thought that traditional healing is a good primary health care system, with 53.3% thinking that traditional healing is safe to use. In addition, over 50% believed that traditional healing can effectively treat psychiatric conditions such as schizophrenia (50.5%) and physiological conditions such as epilepsy (56.1%), as Western medicine does. However, 44.6% were not sure if traditional healing was more holistic in its approach than Western healing. A noteworthy finding was that the greatest majority of the participants did not think (51.5%) or did not agree (20.4%) that the

WHO encourages traditional healing as a primary health care system. These participants found it difficult to even imagine that the WHO is mainly satisfied with traditional healing. Many (51.1%) also did not think that there are hospitals/clinics in South Africa that collaborate with traditional healers.

Table 5.1 Median distributions for opinions, attitudes, knowledge, experiences and intentions variables (N = 319).

Group	N	Opinions Median	Attitudes Median	Knowledge Median	Experiences Median	Intentions Median
Gp1: Psychiatrists	25	2.79	3.00	3.70	1.60	4.00
Gp2: Physicians	37	2.58	2.68	3.60	1.50	3.57
Gp3: General nurses	168	2.68	2.61	3.60	1.75	3.29
Gp4: Psychiatric nurses	89	2.90	3.00	3.70	1.80	3.71
Median: Total group	319	2.68	2.82	3.70	1.70	3.57
Means: Total group	319	2.68	2.78	3.63	1.81	3.42

5.2.1.2 Regulation of traditional healing in South Africa

Nearly half (49.5%) of health care practitioners thought that traditional healing is well regulated in South Africa (see Table 5.2). However, 49.6% were not sure if the training of traditional healers was adequate. Over 40% of health care practitioners thought that the Health Professions Council of South Africa (HPCSA) should formally recognise traditional healing (41.1%) and traditional healers should be allowed to issue medical certificates to their patients (42.6%). Contrary to the above findings, 42.0% and 46.7% of health care practitioners respectively did not think that traditional healing should be encouraged and also did not think that traditional healing was acceptable. Another 46.7% did not even think that a

proper regulation of traditional healing would make it a good health care system (see Table 5.3). A further 41.0 % believed that traditional healing did not have an important role to play in South Africa.

In summary, table 5.2 presents mixed findings regarding health care practitioners' opinions of traditional healing. However, results indicated that they tended to lean towards warming towards the work that traditional healers do. In some instances, health care practitioners showed ambivalence towards traditional healing especially in relation to physiological conditions that can be treated by traditional healers.

Table 5.2 Opinions of traditional healing (N=319)

Item	**Agree/Strongly Agree**		**Not sure**		**Disagree/Strongly Disagree**	
	%	**N**	**%**	**N**	**%**	**N**
Traditional healing in South Africa is well regulated	49.5	158	37.3	119	13.2	42
Training of traditional healers is adequate	38.2	122	49.6	158	12.2	39
Traditional healing is effective in treating psychiatric conditions such as schizophrenia	50.8	162	32.3	103	16.9	44
Traditional healers should be allowed to issue medical certificates to their patients	42.6	136	21.0	67	36.4	116
Traditional healing can effectively treat psychiatric conditions just like Western healing does	50.5	161	29.5	94	20.0	64
Traditional healing is effective in treating physiological conditions such as epilepsy	56.1	179	32.6	104	11.3	36
I am satisfied with the way traditional healing works	63.9	204	24.5	78	11.6	37

Table 5.2 Opinions of traditional healing (N = 319) (continued)

Item	Agree/Strongly Agree		Not sure		Disagree/Strongly Disagree	
	%	N	%	N	%	N
The WHO encourages traditional healing as a primary health care system	28.5	91	51.1	163	20.4	65
Traditional healers should be formally recognised by the HPCSA	41.1	131	25.0	80	33.9	108
Traditional healing is more holistic in its approach than Western healing	32.6	104	44.6	142	22.8	73
Traditional healing is safe to use	53.3	170	34.2	109	12.5	40
In SA, there are hospitals/clinics that collaborate with traditional healers	24.8	79	51.1	163	24.1	77
Traditional healing has an important role to play in SA	27.0	86	32.0	102	41.0	131
Traditional healing is part of people's culture & should be encouraged	32.0	102	26.0	83	42.0	134
Traditional healers are important primary health care providers	42.6	136	30.8	98	26.6	85
Traditional healing is acceptable	26.3	84	27.0	86	46.7	149
Traditional healing is a good primary health care system	57.7	184	23.5	75	18.8	60

Abbreviations: WHO: World Health Organization; **HPCSA:** Health Professions Council of South Africa; **SA:** South Africa

5.2.2 The narratives

This section presents the results of qualitative data analyses in the form of narratives. Open-ended items on the opinions of traditional healing were individually analysed in such a way that each item's responses formed a separate narrative as put forward by the participants.

5.2.2.1 Are there physiological conditions that can be treated by traditional healers?

Almost a third (30.4%, n = 97) of Western-trained health care practitioners thought that there are physiological conditions that can be treated by traditional healers. The following physiological conditions were mentioned: epilepsy, sunken or 'fallen' fontanel, infant rashes, and gastrointestinal conditions such as constipation and diarrhea particularly in children. When they were specifically asked whether they thought that epilepsy could effectively be treated by traditional healing, more than half (56.1%) were of the opinion that that is the case. Some also mentioned that traditional healers can treat herpes zoster, epistaxis (nosebleed), migraine and hiccup. They also mentioned sexually transmitted infections (STIs) in general, but they realised that traditional healers cannot treat HIV infection and Aids.

5.2.2.2 Are there psychiatric conditions that can be treated by traditional healers?

Regarding psychiatric conditions, over a third (38.9%) of the health care practitioners were of the opinion that there are conditions that can be treated by traditional healers. They also thought that traditional healers could effectively treat psychiatric conditions such as clinical depression, schizophrenia (50.8%) or any 'witchcraft-related' psychosis. In this regard, health care practitioners' responses could be summed up by a response of one health care practitioner who responded by saying that "*my brother in-law was a deeply religious person who did not want anything to do with ancestors, but became psychotic and was treated for this, he became much better*". Another responded that *"most psychiatric patients are bewitched and traditional healers are able to heal them*". Once the condition is perceived as man-made (e.g. witchcraft), traditional healing is often preferred over Western medicine (Hoff & Shapiro, 1986). This is because the traditional healing system tailor-makes the healing process in accordance with the patient's cultural background and their understanding of the condition that they could be presenting with (Barsh, 1997). Just over half of health care practitioners thought that traditional healing and Western medicine were equally good in treating psychiatric conditions. One would assume that Western-trained health care practitioners would not have a qualm about the two health care systems sharing a psychiatric patient load since they are perceived as equally good in that regard.

5.2.2.3 Are there conditions that cannot be treated by traditional healers?

Only 8.2% (n = 26) of health care practitioners thought that there are conditions that cannot be treated by traditional healers. Again, as in response to the previous statement about physiological conditions that can be treated by traditional healers, participants reiterated that HIV and Aids are conditions that cannot be treated by traditional healers. In addition, participants mentioned a substantial list of other conditions that cannot be treated by traditional healers including TB, different types of cancer (without mentioning specific examples), surgical problems, cardiovascular conditions, renal failure, diabetes mellitus, asthma, hypertension, acute abdomen, gastroenteritis and pneumonia.

5.2.2.4 Does traditional healing need improvement?

The majority of health care practitioners (55.5%, n = 177) thought that traditional healing needs improvement. The following are comments, about areas in which traditional healing needs improvement, made by health care practitioners in this study: "*their (i.e. traditional healers') training and diagnostics need to be standardized"; "traditional healing needs to be properly regulated"; "traditional healers need to learn about appropriate dosages for their medication"; "traditional healers need to learn to do early referrals to Western doctors"; "traditional healers need to learn about proper personal or general hygiene and infection control/cross infection"*; "*working together with Western medicine and accepting that some conditions are purely medical and that they cannot manage them"*. Participants also thought that traditional healers should improve in relation to initiation schools where the traditional healers could continue to circumcise boys but with improved surgical skills in order to save initiates' lives. They also need to improve in relation to *"handling of body fluids".*

Overall, the health care practitioners' arguments for the improvement of traditional healing revolved around issues of the proper regulation of traditional healing as well as the lack of proper general hygiene practice on the part of traditional healers.

5.2.2.5 Can Western medicine learn from traditional healing?

Just over a quarter (26.3%, n = 84) of the respondents either strongly agreed or agreed that Western medicine can learn from traditional healing. In the words of some of the participants, the following are lessons that Western medicine can learn from traditional healing: *"The use of herbs in effectively treating some conditions such as infertility in women"; "how to appreciate African people's perception of illness without being judgmental"; "how to respect and appreciate the perceptions of Africans towards illness, its causes, management and possible outcome – without judgment"; "learn to treat community members according to their cultural beliefs, norms and values"; "holistic approach to healing which includes treating the whole family and not just the patient"*. Western health care practitioners could further learn about *"the conditions that traditional healers are able to cure or deal with successfully, so that Western healers can refer patients to traditional healers"; "There are some diseases that cannot be healed by Western medicine so they must learn from traditional healers".* The above responses imply that Western medicine alone is not enough to deal with different diseases, and that it needs to work with traditional healing in treating patients.

In summary, between 30% and 39% of health care practitioners were of the opinion that certain physiological and psychiatric conditions such as epilepsy and witchcraft-related psychosis (*mafofonyane*) can be treated by traditional healers. However, HIV, Aids and TB, amongst other conditions, were mentioned as conditions that cannot be treated by traditional healers. Although some health care practitioners were of the opinion that traditional healing can treat some conditions, they also mentioned that traditional healing needed improvement in many areas that included but were not limited to proper personal or general hygiene and cross infection control. Pointing to lessons that can be learned from traditional healing, health care practitioners thought that Western medicine can learn to respect and appreciate African people's perception of illness without being judgmental. Lastly, some health care practitioners thought that Western medicine could learn from traditional healing about the use of herbs in treating some conditions.

5.2.3 Biographical differences regarding opinions of traditional healing

Looking at health care practitioners' biographical data in relation to their opinions of traditional healing, significant differences were found between males (Md = 2.97, n = 88) and

females (Md = 2.58, n = 231), U = 7318.5, z = -3.87, p = 0.000, r = 0.22 (small effect size). Significant differences were also found between Christians (Md = 2.63, n = 226) and both Christians and traditional African religious believers (Md = 3.32, n = 32), U = 1431, z = -5.53, p = 0.000, r = 0.34 (medium effect size). Yet another statistically significant difference was found between health care practitioners working in rural areas (Md = 2.63, n = 217) and health care practitioners working in urban areas (Md = 2.90, n = 102), U = 9400.5, z = -2.17, p = 0.03, r = 0.12 (small effect size). A Kruskal-Wallis Test found no statistically significant differences across the six home languages spoken in terms of their opinions of traditional healing (p = 0.06)

The results showed that health care practitioners who concurrently believed in both Christian and traditional African religions had more positive opinions of traditional healing than any other group in the above analysis. Health care practitioners working in urban areas had slightly more positive opinions of traditional healing than health care practitioners working in rural areas. Males had more positive opinions of traditional healing than females.

5.2.4 Differences between groups in terms of their opinions of traditional healing

To test Hypothesis 1, a Kruskal-Wallis test was used to determine if there were any significant differences between the four categories of health care practitioners (psychiatrists, physicians, general nurses and psychiatric nurses) in terms of their opinions of the traditional healing system.

A Kruskal-Wallis Test revealed a statistically significant difference in opinions of traditional healing across the four groups of health care practitioners (Gp1, n = 25: Psychiatrists, Gp2, n = 37: Physicians, Gp3, n = 168: General Nurses, Gp4, n = 89: Psychiatric Nurses), X^2 (3, n = 319) = 9.45, p = 0.024. An inspection of the median scores for the four groups (see table 5.1) revealed that the psychiatric nurses group had the highest positive opinion scores (Md = 2.90), with the physician group reporting the lowest positive opinion scores (Md = 2.58). A Mann-Whitney U Test revealed a statistically significant difference in opinion levels of physicians (Md = 2.58, n = 37) and psychiatric nurses (Md = 2.90, n = 89), U = 1109.5, z = -2.88, p = 0.004, r = -0.26. The strength (or effect size) of this relationship was small, taking into consideration Cohen's criteria of 0.1 = small effect, 0.3 =

medium effect and 0.5 = large effect (Pallant, 2010). No further statistically significant differences between groups were found.

As hypothesised, there were significant differences between the four groups of health care practitioners in terms of their opinions of traditional healing. The results indicated that psychiatric nurses had significantly more positive opinions of traditional healing than general physicians. It is notable (although not statistically significant) that both psychiatric nurses and psychiatrists had more positive opinions of traditional healing than general nurses and general physicians.

It is thus clear that, in relation to the opinions of health care practitioners, all four categories of them scored just below the midpoint of 3 (on the 1-5 scale), which means that they have very moderate opinions of traditional healing. However, the majority of them believe that traditional healing is a satisfactory and good primary health care system which is safe to use.

5.3 ATTITUDES TOWARDS TRADITIONAL HEALING

The next sub-sections present health care practitioners' attitudes towards traditional healing and in particular their attitudes towards the integration of traditional healing and Western healing, their attitudes towards the safety of traditional healing and their attitudes towards learning about traditional healing. Biographical differences as well as differences between groups of health care practitioners in terms of their attitudes towards traditional healing are discussed.

5.3.1 Descriptive statistics

Health care practitioners expressed moderate attitudes towards traditional healing, with a mean of 2.78 (SD = 0.82, N = 319) on the Attitudes scale which ranged from 1 (negative attitudes) to 5 (positive attitudes) (see Table 5.1).The minimum score obtained was 1.00 and the maximum score was 4.95.

5.3.1.1 Would Western-trained health care practitioners personally use traditional healing?

Western-trained health care practitioners had mixed and often contradictory feelings about the integration of traditional healing and Western medicine in South Africa. Although almost half (49.8%) of participants in the study reported that they would *never* use traditional healing for any reason whatsoever (see Table 5.3), 55.5% indicated on another question that they would consider consulting traditional healers in the future. A notable 69.3% of Western-trained health care practitioners would consider using a combination of both traditional healing and Western medicine when they are ill. The majority (66.5%) of them also indicated that they would seek help from traditional healers even when Western medicine was available.

5.3.1.2 Would Western-trained health care practitioners refer patients to traditional healers?

Referral of patients to traditional healers by Western-trained health care practitioners has always been a contentious issue, with traditional healers lamenting the fact that referral of patients seems to be a one-way process in which traditional healers refer patients to Western-trained health care practitioners without reciprocation.

In this study, Western-trained health care practitioners appeared to be tilting in favour of making referrals a two-way process. Just over 47% said that they would collaborate with traditional healers in treating patients, if given an opportunity to do so. The majority (62.1%) would consider referring patients to traditional healers. However, 43.9% would not encourage any use of traditional healing.

5.3.1.3 Would Western-trained health care practitioners support the integration of traditional healing and Western medicine?

In light of the above generally favourable attitudes towards traditional healing, one would expect that a relatively large percentage of Western-trained health care practitioners would

favour formal integration of traditional healing and Western medicine. On the contrary, 50.5% felt that although traditional healing is important for maintenance of health, it should continue to be separate from Western medicine. This was corroborated by a further 42.6% who did not think that Western medicine and traditional healing could improve health care if they worked together. On the question of whether the integration of traditional healing and Western medicine would work, 35.1% felt that it would not and 34.5% felt that it would. If traditional healing and Western medicine were to be integrated, 43.6% of Western-trained health care practitioners would support it while 38.2% would not.

Table 5.3 Attitudes towards traditional healing (N = 319)

Item	**Agree/Strongly agree**		**Not sure**		**Disagree/strongly disagree**	
	%	**N**	**%**	**N**	**%**	**N**
I would support integration of TH & WH	43.6	139	18.2	58	38.2	122
I would not encourage anybody to use TH	43.9	140	20.3	65	35.8	114
WH & TH could improve health if worked together	35.7	114	21.7	69	42.6	136
I would collaborate with THs in treating patients	47.3	151	16.9	54	35.8	114
I would never use TH for any reason	49.8	159	21.3	68	28.9	92
TH should continue to be separate from WH	50.5	161	13.4	43	37.1	115
If proper regulation of TH, TH would be a good system	23.5	75	29.8	95	46.7	149
TH is important for maintenance of health	50.5	161	21.3	68	28.2	90
TH cannot be trusted	42.0	135	27.3	87	30.7	98
Government is doing well by supporting TH	28.2	90	31.0	99	40.8	130
I would consider referring patients to THs	62.1	198	21.9	70	16.0	51
TH should be discarded	22.6	72	31.7	101	45.7	146

Table 5.3 Attitudes towards traditional healing (N = 319) (continued)

Item	Agree/Strongly Agree		Not sure		Disagree/Strongly Disagree	
	%	N	%	N	%	N
When people ill, should see Western doctors & not THs	53.9	172	18.2	58	27.9	89
Integration of TH and WH will not work	35.1	112	30.4	97	34.5	110
I want to learn more about TH	38.2	122	16.0	51	45.8	146
I would consider consulting THs in the future	55.5	177	25.1	80	19.4	62
TH is dangerous	41.1	131	36.0	115	22.9	73
When ill, I consider both TH and WH	69.3	221	6.9	22	23.8	76
TH belongs in the olden days	35.4	113	20.1	64	44.5	142
I would seek help from THs even when Western medicine is available	66.5	212	15.7	50	17.8	47
Medical aid schemes should not recognise TH	41.1	131	22.5	72	36.4	116

Abbreviations: TH: Traditional healing; **WH:** Western healing; **THs:** Traditional healers

5.3.1.4 Safety of traditional healing

Just over 40 percent (41.1%) of Western-trained health care practitioners felt that traditional healing was dangerous and that it should not be recognised by medical aid schemes. A further 42% felt that traditional healing could not be trusted. However, while many thought that traditional healing could not be trusted, 45.7% felt that traditional healing should not be discarded. Only a relatively small percentage (28.2%) felt that the government was doing well by supporting traditional healing. More than half (53.9%) felt that when people are ill they should see Western-trained medical practitioners and not traditional healers.

5.3.1.5 Learning about traditional healing

Just over 45 percent (45.8%) of health care practitioners would not want to learn more about traditional healing while 38.2% would. A further 35.4% indicated that traditional healing belonged in the olden days, and they would therefore not be interested in learning about it.

In conclusion, health care practitioners generally viewed traditional healing in a positive light yet they indicated their reluctance to support a formal integration of the two health care systems. Just over half of the participants would prefer that traditional healing should continue to be separate from Western medicine despite acknowledging the importance of traditional healing for the maintenance of health.

5.3.2 Biographical differences regarding attitudes towards traditional healing

An analysis of the health care practitioners' biographical data in relation to their attitudes towards traditional healing showed significant differences between males (Md = 3.11, n = 88) and females (Md = 2.64, n = 231), U = 7459, z = -3.68, p = 0.000, r = 0.21 (small effect size). Significant differences were also found between Christians (Md = 2.64, n = 226) and both Christians and traditional African religious believers (Md = 3.32, n = 32), U = 1376, z = -5.67, p = 0.000, r = 0.35 (medium effect size). Another significant difference was observed between health care practitioners working in rural areas (Md = 2.64, n = 217) and those working in urban areas (Md = 3.09, n = 102), U = 8630.5, z = -3.17, p = 0.002, r = 0.18 (small effect size). A Kruskal-Wallis Test found no statistically significant differences across the six home language groups (p = 0.12).

In summary, health care practitioners concurrently practicing both Christian and traditional African religions had more positive attitudes towards traditional healing than any other religious group. Those working in urban areas showed more positive attitudes than those working in rural areas, and males had more positive attitudes towards traditional healing than females.

5.3.3 Differences between groups in terms of their attitudes towards traditional healing

To test Hypothesis 2, a Kruskal-Wallis test was computed to determine if there were significant differences between the four categories of health care practitioners in terms of their attitudes towards traditional healing.

It revealed a statistically significant difference in attitudes towards traditional healing across the four groups of health care practitioners (Gp1, n = 25: Psychiatrists, Gp2, n = 37:

Physicians, Gp3, n = 168: General Nurses, Gp4, n = 89: Psychiatric Nurses), X^2 (3, n = 319) = 9.07, p = 0.028. The results showed that psychiatrists and psychiatric nurses had the highest attitudes scores (both Md = 3.00), with general nurses having the lowest attitudes score (Md = 2.61). Physicians had slightly more positive attitudes (Md = 2.68) towards traditional healing than general nurses (see Table 5.1).

A Mann-Whitney U Test revealed a significant difference in attitude levels of psychiatrists (Md = 3, n = 25) and general nurses (Md = 2.61, n = 168), U = 1538, z = -2.16, p = 0.03, r = -0.16 (small effect size), with psychiatrists having more positive attitudes towards traditional healing than general nurses. A Mann-Whitney U Test also revealed a significant difference in attitude levels of general nurses (Md = 2.61, n = 168) and psychiatric nurses (Md = 3, n = 89), U = 6080.5, z = -2.462, p = 0.02, r = -0.154 (small effect size), with psychiatric nurses having more positive attitudes towards traditional healing than general nurses.

As hypothesised, there were significant differences between the four categories of health care practitioners in terms of their attitudes towards traditional healing. These results indicate that psychiatric nurses and psychiatrists had more positive attitudes towards traditional healing than general nurses and physicians.

In conclusion, in relation to the attitudes of health care practitioners their scores, which hovered around the midpoint of 3, indicate that they have moderate attitudes towards traditional healing, with the majority equally considering both traditional healing and Western medicine when they are ill.

5.4 KNOWLEDGE OF TRADITIONAL HEALING

Health care practitioners' knowledge of traditional healing was examined based on the published literature on traditional healing. Below, descriptive statistics are first presented followed by the narratives in relation to health care practitioners' knowledge of traditional healing. Biographical and group differences in terms of their knowledge of traditional healing are then discussed.

5.4.1 Descriptive statistics

Health care practitioners obtained a mean of 3.63 (SD = 0.53, N = 319) on the Knowledge Scale which ranged from 1 (less knowledge) to 5 (more knowledge). The minimum score obtained was 1.00 and the maximum score was 5.00 (see Table 5.1).

Knowledge among all four categories of Western-trained heath care practitioners about traditional healing seemed to be uniform and just above the midpoint of 3. A closer look at the frequencies on the individual knowledge items, however, tells a different story and indicates that health care practitioners' knowledge of traditional healing was generally poor and was different from the published knowledge in the literature. This finding is surprising because most of the participants had African languages as their home languages, and most of them lived and worked in areas where traditional healing was, according to the literature, widely used. The majority of health care practitioners (79.3 %) did not know that in traditional healing there are illnesses that are believed to be caused by witchcraft/sorcery or the ancestors (70.8%) (see Table 5.4). Just under two-thirds (62.7%) of health care practitioners did not know that ancestral spirits are pillars of traditional healing. A two-thirds majority (66.7%) did not know that there are some Christians who consult traditional healers. In addition, 56.4% did not know that some traditional healers are also Christians. A further 33.3% were not sure if some traditional healers are Christians.

Contrary to commonly cited research on the use of traditional healing services by Africans in South Africa, only 6.9% of health care practitioners knew that approximately 80% of blacks in South Africa use the services of traditional healers. Over half (51.5%) disagreed with this statement, and a further 42.6% were not sure if it is true that approximately 80% of blacks use traditional healing.

The literature indicated that traditional healing uses animal products, plant products and mineral substances to treat illnesses, and that traditional healers use patients' cultural beliefs about health and illness along with physical, social and spiritual data to make a diagnosis. However, only 2.1% knew that traditional healing uses animal, plant products as well as mineral substances to treat illnesses. A further 43.3% were not sure if traditional healing uses these products and substances; and almost half (49.8%) were not sure that in traditional healing, patients' cultural beliefs of health and illness are used along with physical, social and spiritual data to make a diagnosis.

Over half (54.8%) of health care practitioners did not think that traditional healing was accepted in their communities. A further 31.7% did not know or were not sure if it was. Only a relatively small percentage (17.9%) thought that traditional healing will continue to exist for a long time.

In summary, a large majority of the health care practitioners who took part in this study appeared to have a limited knowledge of traditional healing. In many cases, this lack of knowledge was manifested in items where they responded by indicating that they were 'not sure' about some aspects that relate to traditional healing.

Table 5.4 Knowledge of traditional healing (N = 319)

Item	**Agree/Strongly Agree**		**Not sure**		**Disagree/Strongly Disagree**	
	%	**N**	**%**	**N**	**%**	**N**
There are some Christians who consult THs	7.2	23	26.1	83	66.7	213
In TH there are illnesses that are believed to be inflicted by ancestors	3.8	12	25.4	81	70.8	226
± 80% of blacks in SA use services of THs	6.9	22	42.6	136	51.5	161
Some THs are Christians	10.3	33	33.3	106	56.4	180
TH uses animal, plant products & mineral substances to treat illnesses	2.1	7	43.3	138	54.6	174
In TH cultural beliefs, physical , social & spiritual data are used to make a diagnosis	8.5	27	49.8	159	41.7	133
TH is accepted by my community	13.5	43	31.7	101	54.8	175
In TH there are illnesses that are believed to be caused by witchcraft/sorcery	2.5	8	18.2	58	79.3	253
TH is here to stay	17.9	57	24.7	79	57.4	183
Ancestral spirits are pillars of TH	1.9	6	35.4	113	62.7	200

Abbreviations: TH: Traditional healing; **THs:** Traditional healers

5.4.2 The narratives

This section presents the results of participants' responses to the open-ended items in the form of narratives as related by the participants. Open-ended items were individually analysed in such a way that each item's responses formed a separate narrative as put forward by the participants.

5.4.2.1 Does one have to be trained to qualify as a traditional healer?

Over half (52.7%; n= 168) of participants agreed with the statement that one has to be trained to qualify as a traditional healer. Participants mentioned a "*senior or experienced traditional healer*", commonly called "*Kobela*", as being the appropriate person to train prospective traditional healers, with some health care practitioners mentioning the name of a well-known senior traditional healer trainer in the Grobblersdal area in Limpopo province. This healer is well known in Limpopo and in other provinces; for ethical reasons, his name is not mentioned here. Some health care practitioners responded by just saying that they do not know if one has to be trained to qualify as a traditional healer. This, as was the case with descriptive statistics (above), indicated a limited knowledge of traditional healing on the part of some of the Western-trained health care practitioners.

5.4.2.2 Is traditional healing accepted in your community?

Only 13.5% (n = 43) of participants agreed with the statement that traditional healing is accepted by their communities. On why they thought that traditional healing was accepted by their communities, participants responded that *"Traditional healing is part of the community's culture and traditional healers are readily available"; " the community was taught, as part of their culture, to believe in traditional healing"; "in many cases, people in the community believe that their illnesses are caused by witchcraft or sorcery and therefore traditional healers are the first port of call; " traditional healing works for them".*

In summary, Western-trained health care practitioners showed a general lack of knowledge of traditional healing. In addition, high levels of uncertainty about aspects of

traditional healing were evident. These uncertainties might have contributed to their general lack of knowledge of traditional healing.

5.4.3 Biographical differences regarding knowledge of traditional healing

Inspection of biographical data in relation to health care practitioners' knowledge of traditional healing revealed significant differences between males (Md = 3.7, n = 88) and females (Md = 3.6, n = 231), U = 8660.5, z = -2.05, p = 0.04, r = 0.12 (small effect size). Statistically significant differences were also found between Christians (Md = 3.6, n = 226) and those who concurrently believe in both traditional African and Christian religions (Md = 4.0, n = 32), U = 1729, z = -4.79, p = 0.000, r = 0.3 (medium effect size). No statistically significant difference was found between health care practitioners working in rural areas and those working in urban areas (p = 0.11). Furthermore, a Kruskal-Wallis Test found no statistically significant differences across the six home language speakers (p = 0.44).

Overall, the group of health care practitioners who concurrently believed in both Christianity and traditional African religion had more knowledge of traditional healing than any other religious group. Male participants had slightly more knowledge of traditional healing than female participants.

5.4.4 Differences between groups in terms of their knowledge of traditional healing

To test Hypothesis 3, a Kruskal-wallis Test was performed to determine if there were any significant differences between the four categories of health care practitioners in terms of their knowledge of traditional healing.

The test revealed no statistically significant difference in knowledge of traditional healing across the four groups of health care practitioners (Gp1, n = 25: Psychiatrists, Gp2, n = 37: Physicians, Gp3, n = 168: General Nurses, Gp4, n = 89: Psychiatric Nurses), X^2 (3, n = 319) = 5.96, p = 0.113. Contrary to hypothesis Three (3), the results revealed no significant difference between the four categories of health care practitioners in terms of their knowledge of traditional healing. Therefore the hypothesis could not be confirmed.

In conclusion, on the knowledge of traditional healing it is clear that health care practitioners have a very limited knowledge of traditional healing despite scoring just above the midpoint of 3. It is not clear if they really know so little about traditional healing, or if for various reasons they were not willing to share the fact that they do have some knowledge of it.

5.5 EXPERIENCES WITH TRADITIONAL HEALING

This section describes health care practitioners' experiences with traditional healing. It combines both direct experiences by health care practitioners and indirect ones, through their friends, colleagues, patients or relatives.

5.5.1 Descriptive statistics

The results indicated that health care practitioners had very little experience with traditional healing, with a mean of 1.81 (SD = 0.57, N =319) on the Experiences Scale which ranged from 1 (less experience) to 5 (more experience) (see Table 5.1). The minimum score obtained was 1.00 and the maximum score was 4.80.

Although results in Table 5.3 about attitudes indicate that 55.5% of health care practitioners who participated in this study would consider consulting traditional healers when they are ill, table 5.5 reveals that 92.8% (n = 296) of health care practitioners never or seldom consult traditional healers. Only 7.1% (n = 23) health care practitioners said that they often or always consult them. More than ten percent of health care practitioners (11.3%) have often or always consulted traditional healers before they qualified as health care practitioners, while only 0.9% reported that they often or always consulted traditional healers after they qualified. The majority never or seldom consulted traditional healers before they qualified as health care practitioners (88.7%) or after they qualified (90.9%).

Most of the health care practitioners (95.6%, n = 305) reported that they seldom or never refer patients to traditional healers. On the other hand, 43.3% of health care practitioners have often or always treated patients who were referred to them by traditional healers. In addition, 66.8% (n= 213) of health care practitioners said that they had seldom or

never seen patients who were effectively treated by traditional healers. This means, however, that a third (33.2%) of the health care practitioners did often or always see patients who were effectively treated by traditional healers. Only 10.3% indicated that traditional healers often or always shared knowledge of traditional health care with them, in the form of workshops, one-on-one conversations and so on. This implies that there is very little professional interaction between traditional healers and Western-trained health care practitioners.

Just over a quarter of health care practitioners (26.9%) have often or always heard of Western-trained health care practitioners who consult traditional healers when ill. A similar percentage of health care practitioners (27.6%) have often or always heard of other Western-trained health care practitioners who consult traditional healers for reasons other than illness.

Although not many health care practitioners indicated that they themselves make use of the services of traditional healers, 44.8% said that they have friends who often or always do so.

In summary, health care practitioners in this study do not seem to have much experience with traditional healing. Only a small number (7.1%) of health care practitioners reported some direct experience with traditional healing by either often or always consulting traditional healers themselves or by often or always referring patients to traditional healers (4.4%). There therefore seems to be a disparity between what health care practitioners actually do and what they say they are prepared to do regarding utilisation of the services of traditional healers. Nonetheless, health care practitioners are aware of the importance of traditional healing in their communities.

Table 5.5 Experiences with traditional healing (N = 319)

Item	Never/Seldom		Regularly/Often		Always	
	%	N	%	N	%	N
I have consulted THs after I qualified as a HC practitioner	90.9	290	8.2	26	0.9	3
I have consulted THs before I qualified as a HC practitioner	88.7	283	9.1	14	2.2	7
I have seen patients who were effectively treated by THs	66.8	213	25.4	81	7.8	25
I do refer patients to THs	95.6	305	3.5	11	0.9	3
I often consult a TH	92.8	296	6.6	21	0.6	2
Some of my friends consult THs	55.2	176	36.0	115	8.8	28
I have heard of W-HC practitioners who consult THs for reasons other than illness	72.4	231	24.5	78	3.1	10
THs often share knowledge of HC with me	89.7	286	9.7	31	0.6	2
Have heard of W-HC practitioners who consult THs when ill	73.0	233	24.5	78	2.5	8
I have treated patients referred by THs	56.7	181	34.2	109	9.1	29

Abbreviations: THs: Traditional healers; **HC:** Health care; **TH:** Traditional healing; **W-:** Western-trained

5.5.2 Biographical differences regarding experiences with traditional healing

In relation to health care practitioners' experiences with traditional healing, statistically significant differences were found between Christians (Md = 1.65, n = 226) and those who believed in both Christianity and traditional African religion (Md = 1.95, n = 32), U = 2389, z = -3.11, p = 0.002, r = 0.19 (small effect size). Significant differences were also found between health care practitioners working in rural areas (Md = 1.80, n = 217) and health care practitioners working in urban areas (Md = 1.60, n = 102), U = 8298, z = -3.61, p = 0.000, r =

0.2 (small effect size). Furthermore, statistically significant differences were found across the six home language speakers (Sepedi, n = 149: Zulu, n = 31: Xhosa, n = 15: Tsonga, n = 14: Venda, n = 10: English, n = 26), $X^2(5, n = 245) = 25.02$, p = 0.000. Sepedi-speaking and Zulu-speaking groups recorded a higher median score (both Md = 1.8) than the other language speakers, which all recorded median values of 1.7 or less.

Overall, health care practitioners who concurrently believed in both Christianity and traditional African religion showed that they had more experiences with traditional healing than any other group. Health care practitioners in rural areas had more experiences with traditional healing than those in urban areas, and Sepedi- and Zulu-speaking participants had more experiences with traditional healing than the rest of the language groups in the analysis.

5.5.3 Differences between groups in terms of their experiences with traditional healing

To test Hypothesis 4, a Kruskal-Wallis Test was computed to determine if there were significant differences between the four categories of health care practitioners in terms of their experiences with traditional healing.

The test revealed statistically significant differences in experiences with traditional healing across the four groups of health care practitioners (Gp1, n = 25: Psychiatrists, Gp2, n = 37: Physicians, Gp3, n = 168: General Nurses, Gp4, n = 89: Psychiatric nurses), X^2 (3, n = 319) = 17.84, p = 0.000. An inspection of the scores revealed that psychiatric nurses had the highest experiences scores (Md = 1.80), while physicians had the lowest experiences scores (Md = 1.50). A Mann-Whitney U Test revealed a significant difference in experiences levels of psychiatrists (Md = 1.6, n = 25) and general nurses (Md = 1.75, n = 168), U = 1465, z = -2.44, p = 0.02, r = -0.18, (with a small effect size). This means that general nurses had slightly more experiences with traditional healing than psychiatrists. A Mann-Whitney U Test further indicated significant difference in experience levels of psychiatric nurses (Md = 1.8, n = 89) and psychiatrists (Md = 1.6, n = 25), U = 765.5, z = -2.38, p = 0.02, r = 0.22 (small effect size). This implies that psychiatric nurses had slightly more experiences with traditional healing than psychiatrists. A Mann-Whitney U Test also revealed a significant difference in experiences levels of physicians (Md = 1.5, n = 37) and general nurses (Md = 1.75, n = 168), U = 1981.5, z = -3.456, p = 0.001, r = -0.24 (also a small effect size) which indicates that general nurses had slightly more experiences with traditional healing than

physicians. Yet another significant difference was revealed in experiences levels of physicians (Md = 1.5, n = 37) and psychiatric nurses (Md = 1.8, n = 89), U = 1024, z = -3.344, p = 0.001, r = -0.3. This would be considered a medium effect size. This indicates that psychiatric nurses had moderately more experiences with traditional healing than physicians.

As hypothesised, there were significant differences between the four categories of health care practitioners in terms of their experiences with traditional healing. Overall, psychiatric nurses and general nurses had more experiences with traditional healing than psychiatrists and physicians.

In conclusion, on the experiences of health care practitioners it is clear that health care practitioners did not have much experience with traditional healing, with scores well below the midpoint of 3. It is not clear whether health care practitioners indeed did not have much experience with traditional healing or they were reticent about such experience.

5.6 INTENTIONS TO WORK WITH TRADITIONAL HEALERS

This section presents health care practitioners' behavioural intentions to work with traditional healers in the future. In general, they indicated such a willingness, with a mean of 3.42 (SD = 1.08, N = 319) on the Intentions Scale which ranged from 1 (unwillingness to work with traditional healers) to 5 (willingness to work with traditional healers) (see Table 5.1). The minimum score obtained was 1.00 and the maximum score was 5.00.

5.6.1 Descriptive statistics

The majority of the health care practitioners who participated in the study had no intentions to share knowledge about hygiene with traditional healers (84.4%) nor were they prepared to attend joint workshops/discussions with traditional healers (67.4%) (see Table 5.6) . In addition, 66.5% were not prepared to visit traditional healers' consulting rooms even if the visit was just to observe how the healers work. This is in contrast with 42.3% of health care practitioners who would absolutely or maybe encourage other health care practitioners to learn about traditional healing. This finding may suggest that many health care practitioners would rather have their colleagues learn about traditional healing than learn about it

themselves. They may feel that others would look down on them if they indicated a willingness to learn about traditional healing. Only 22.9% indicated an intention to absolutely or maybe collaborate with traditional healers if such healers were properly regulated by the State. A further 38.9% would absolutely or maybe support the integration of traditional healing and Western medicine. However, a notable 23% were not sure if they were prepared to support the integration of traditional healing and Western medicine. Just over half (50.5%) were prepared to work with a specific type of traditional healer called the traditional birth attendant.

In summary, the majority of health care practitioners indicated an unwillingness to work with traditional healers in general. However, just over half would be willing to work with one category of traditional healers, namely traditional birth attendants.

Table 5.6 Intentions to work with traditional healers in the future (N = 319).

Item	**Absolutely**		**Maybe**		**Not sure**		**Not Likely/ Not at all**	
	%	**N**	**%**	**N**	**%**	**N**	**%**	**N**
I would like to attend joint workshops/discussions with THs	15.0	48	5.3	17	12.3	39	67.4	215
I would like to share knowledge about hygiene with THs	7.5	24	3.1	10	5.0	16	84.4	269
I am prepared to visit THs' rooms just to observe how THs work	16.3	52	6.2	20	11.0	35	66.5	212
I would only collaborate with THs if they are properly regulated	12.9	41	10.0	32	18.8	60	58.3	186
I would encourage other HC practitioners to learn more about TH	28.8	92	13.5	43	13.8	44	43.9	140
I am prepared to support the integration of TH with WH	26.0	83	12.9	41	23.5	75	37.6	120
I am prepared to work with a traditional birth attendant	36.4	116	14.1	45	16.3	52	33.2	106

Abbreviations: THs: Traditional healers; **HC:** Health care; **TH:** Traditional healing; **WH:** Western healing

5.6.2 Biographical differences regarding intentions to work with traditional healers

Inspection of the biographical data in relation to health care practitioners' intentions to work with traditional healers revealed significant differences between males (Md = 3.93, n = 88) and females (Md = 3.43, n = 231), U = 8419.0, z = -2.37, p = 0.02, r = -0.13 (small effect size). Statistically significant differences were found between health care practitioners working in rural areas (Md = 3.43, n = 217) and those working in urban areas (Md = 3.79, n = 102), U = 9189.5, z = -2.45, p = 0.01, r = -0.14 (small effect size). Yet another statistically significant difference was found between Christians (Md = 3.57, n = 226) and those who concurrently believed in both Christian and traditional African religion (Md = 4.43, n = 32), U = 1988.0, p = 0.00, r = -0.26 (small effect size). A Kruskal-Wallis Test found no statistically significant differences across the six home language speakers (p = 0.20).

In summary, health care practitioners who concurrently believed in both Christian and traditional African religion showed more willingness to work with traditional healers in the future than any other group. Males were more willing to work with traditional healers than females; and health care practitioners working in urban areas were more willing to work with traditional healers than were those working in the rural areas.

5.6.3 Differences between groups in terms of their intentions to work with traditional healers in the future

To test Hypothesis 5, a Kruskal-Wallis Test was performed to determine if there were significant differences between the four categories of health care practitioners in terms of their intentions to work with traditional healers in the future.

The test revealed statistically significant differences in intentions to work with traditional healers across the four groups of health care practitioners (Gp1, n = 25: Psychiatrists, Gp2, n = 37: Physicians, Gp3, n = 168: General nurses, Gp4, n = 89: Psychiatric nurses) X^2 (3, n = 319) = 12.87, p = 0.005. An inspection of the scores indicated that psychiatrists had the highest intentions scores (Md = 4.00) while general nurses had the lowest intentions scores (Md = 3.29). Psychiatric nurses had the second highest score (Md = 3.71) followed by physicians (Md = 3.57).

A Mann-Whitney U Test revealed a statistically significant difference in intentions between psychiatrists (Md = 4.00, n = 25) and general nurses (Md = 3.29, n = 168), U = 1442.0, z = -2.53, p = 0.01, r = -0.18 (small effect size). Another significant difference was found between psychiatric nurses (Md = 3.71, n = 89) and general nurses (Md = 3.29, n = 168), U = 5721.0, z = -3.10, r = -0.19 (small effect size).

As hypothesised, there were significant differences between the four categories of health care practitioners in terms of their intentions to work with traditional healers in the future. Overall, psychiatrists and psychiatric nurses showed more willingness to work with traditional healers than did physicians and general nurses, in that order.

In conclusion, on the intentions of health care practitioners it is clear that all four categories of health care practitioners scored above the midpoint of 3 (on the 1-5 scale), which means that there is a willingness to work with traditional healers and particularly with traditional birth attendants in the future.

The next section presents the results of multiple regression analysis in which health care practitioners' *intentions* to work with traditional healers are predicted on the basis of their *opinions*, *attitudes*, *knowledge* and *experiences* with traditional healing.

5.7 PREDICTING BEHAVIOURAL INTENTIONS TO WORK WITH TRADITIONAL HEALERS IN THE FUTURE

An aim of this study was to investigate if *opinions*, *attitudes*, *knowledge* and *experiences* with traditional healing impact on health care practitioners' *intentions* to use the services of traditional healers in the future. The study hypothesised that a significant proportion of Western-trained health care practitioners' intentions to work with traditional African healers would be explained by their opinions, attitudes, knowledge and experiences with the traditional African healing system (**Hypothesis 6**).

To test this hypothesis, a standard multiple regression analysis using the 'Enter' method was performed. Note that all the assumptions for computing a standard multiple regression were met by the data of this study; see Chapter 4, Section 4.9.1.

Four predictor variables were used namely, *opinions, attitudes, knowledge,* and *experiences*. The dependent (criterion) variable was behavioural *intentions*. Correlations between the criterion variable (i.e. behavioural intentions) and each predictor variable (i.e. opinions, attitudes, knowledge and experiences) were acceptable (i.e. r > 0.3) (see Table 5.7 for Pearson correlations table). Thus, these values are acceptable for standard multiple regression analysis (Brace et al., 2003, Pallant, 2010).

Table 5.7 shows that correlations between the predictor variables are not high (<0.6) apart from the correlation between attitudes and opinions (r = 0.816). However, this higher correlation did not appear to weaken the regression model, hence both variables were included in the final model.

Table 5.7 Pearson product moment correlation coefficients for intentions, attitudes, opinions, experiences and knowledge (N = 319)

	Intentions	**Attitudes**	**Opinions**	**Experiences**	**Knowledge**
Intentions	*	0.690	0.631	0.313	0.516
Attitudes	0.690	*	0.816	0.376	0.559
Opinions	0.631	0.816	*	0.427	0.528
Experiences	0.313	0.376	0.427	*	0.428
Knowledge	0.516	0.559	0.528	0.428	*

To compute the standard multiple regression analysis, all 319 participants' responses were pooled and analysed as one group. The means and standard deviations for the variables included in the overall standard multiple regression analysis are presented in Table 5.8 below.

Table 5.8 Means and standard deviations for standard multiple regression variables (N = 319)

Variable	Mean	Std Deviation	N
Intentions	3.42	1.08	319
Opinions	2.68	0.72	319
Attitudes	2.78	0.82	319
Knowledge	3.63	0.57	319
Experiences	1.81	0.61	319

The standard multiple regression analysis using the 'Enter' method was used to assess the ability of health care practitioners' opinions, attitudes, knowledge and experiences with traditional healing to predict their behavioural intentions of working with traditional healers in the future. All predictor variables were assessed simultaneously.

The predictor variables (opinions, attitudes, knowledge and experiences) explained 51% of the total variance of health care practitioners' intentions to work with traditional healers in the future, $F(4, 314) = 81.56$, $p < 0.0005$ (see Table 5.9 below).

In the model, three out of four predictor variables were statistically significant, with the Attitudes scale recording the highest beta value (beta = 0.457, $p < 0.0005$), the Knowledge scale having a beta value of 0.175 ($p = 0.001$) and the Opinions scale a beta value of 0.168 ($p < 0.05$) (see Table 4.2 above). The Experiences scale recorded the lowest beta value of -0.005.

The *attitudes* variable made the strongest unique contribution to explaining health care practitioners' intentions of working with traditional healers in the future (7%), when the variance explained by *opinion*s, *knowledge* and *experiences* in the model was controlled for (see Table 4.2). The *knowledge* variable made the second strongest unique contribution (1.9%). The lowest unique contributions of 0.9% and 0.003% were made by the *opinions* variable and the *experiences* variable in that order.

As hypothesised, health care practitioners' opinions, attitudes, knowledge and experiences with traditional healing explained a significant proportion of their intentions to work with traditional healers in the future (51%). In statistical terms, this is a highly regarded result of multiple regression analysis (Pallant, 2010).

Table 5.9 Regression model summary and ANOVA (N = 319)

Model	R	R Square	Adjusted R Square	Std Error of the Estimate	Df	F	Sig.
Regression	0.714	0.510	0.503	0.75879	4	81.558	0.000
Residual					314		

5.8 CONCLUSION

The results of this study show significant differences between groups of health care practitioners in terms of their opinions, attitudes, experiences and intentions to work with traditional healers in the future. No statistically significant differences were found in relation to health care practitioners' knowledge of traditional healing, which is surprisingly limited given what is published in the literature. Psychiatrists and psychiatric nurses indicated more positive opinions, more positive attitudes and more experiences with traditional healing than physicians and general nurses. Psychiatrists and psychiatric nurses also indicated more willingness to work with traditional healers in the future than did physicians and general nurses.

When health care practitioners were further divided according to different demographic variables such as gender, religion, area and language, results varied, with health care practitioners who concurrently believed in both Christianity and traditional African religions indicating more positive opinions and attitudes, more experiences of and more willingness to work with traditional healers in the future. Male health care practitioners had more positive opinions and attitudes, slightly more knowledge and indicated more willingness to work with traditional healers than did female health care practitioners. Health

care practitioners working in urban areas had more positive opinions and attitudes, less experience but showed more willingness to work with traditional healers than did health care practitioners working in rural areas. Overall, health care practitioners' intentions to work with traditional healers in the future could be predicted by their attitudes, knowledge, opinions and experiences, with attitudes appearing as the strongest predictors followed, in that order, by knowledge, opinions and experiences with traditional healing.

The next and final chapter further interprets these findings and locates them within the current discourse on traditional healing and Western healing. The chapter also discusses practical implications for the integration of the traditional and the Western health care systems in South Africa. Methodological weaknesses in the current study are discussed. Lastly, the chapter makes recommendations for future research in the traditional healing–Western healing area.

CHAPTER SIX

DISCUSSION

6.1 INTRODUCTION

Traditional African healing plays a vital role in the health care system in South Africa and elsewhere in the African continent. The literature on it estimates that the overwhelming majority of black people in the country use the services of traditional healers (Bodeker, 2001; Bodibe, 1993; Nyika, 2006; Ramgoon et al., 2011). This attests to the high demand for traditional healing in black communities, which are the majority in South Africa (McKean & Mander, 2007). Traditional healers are readily available in black communities, with a very high ratio of traditional healers to the general population of users of their services (1:500) compared to the relatively low ratio of Western-trained medical practitioners to the general population of 1:40 000 (Crawford & Lipsedge, 2004; Truter, 2007). There are thus more traditional healers to treat fewer people than there are Western-trained medical practitioners.

For many consumers of traditional healing, it is used jointly with Western medicine and yet the two health care systems have not been formally integrated in South Africa and traditional healing is not even recognised by entities such as the Health Professions Council of South Africa, the Medicines Control Council and medical aid schemes (Puckree et al., 2002). The National Department of Health has opted for a tolerance approach in relation to traditional healing. Thus, traditional healers can continue to operate for as long as they do not put their clients or patients in danger. Since the start of the democratic dispensation in 1994, the government has been proposing to integrate traditional healing and Western medicine in State hospitals and clinics. This has been welcomed in some quarters such as traditional healer organisations but heavily criticised by others such as Doctors for Life who opposed the integration of traditional healing and Western medicine even before the advent of democracy (Van Eeden, 1993).

The current study was therefore informed by, amongst other points, the challenges of human resources in the health care sector and particularly the shortage of Western-trained health care practitioners in State clinics and hospitals, as can be seen in the ratios cited above, as well as in ongoing formal and informal debates and discussions in the South African health

care sector. These revolve around the possibility of integrating the traditional health care model with the Western medical model (Mills et al., 2005). The World Health Organization has long been a proponent of encouraging governments, particularly in the developing world, to integrate traditional healing into mainstream health care systems to help alleviate the problems that primary health care encounters in developing countries (Gort, 1989).

One of the problems relating to the proposal to integrate traditional healing and Western medicine is that the willingness, or lack thereof, of Western-trained medical practitioners to work with traditional healers has not been thoroughly and widely investigated. This is what the current study set out to do: to determine health care practitioners' intentions to work with traditional healers in the future. This is a matter that South Africa needs to investigate urgently in order to formulate a health care policy that seeks either to integrate the two health care systems or leave them apart.

The study aimed to explore Western-trained health care practitioners' (psychiatrists, physicians, general nurses and psychiatric nurses) *opinions* of, *attitudes* towards, *knowledge* of and *experiences* with traditional African healing and to investigate how these factors impact on the practitioners' *intentions* to work with traditional African healers in the future. The study investigated health care practitioners' demographic data to determine if there were differences between groups in terms of their opinions, attitudes, knowledge and experiences with traditional healing. Underlying the investigation was the conviction that an understanding of Western-trained health care practitioners' opinions, attitudes, knowledge, experiences and their intentions to work together with traditional healers would contribute to guiding the proposed integration process as well as its sustainability in South Africa.

6.2 HEALTH CARE PRACTITIONERS' AMBIVALENCE ABOUT TRADITIONAL HEALING

The study unearthed mixed feelings about traditional healing. Some health care practitioners expressed negative and disapproving sentiments while others were positive and approving. A further group of health care practitioners were hesitant to let their sentiments on traditional healing be known. This ambivalence about traditional healing is reflected upon in this section.

6.2.1 "I don't use them, but my friends do"

Over half of the Western-trained health care practitioners thought that traditional healing is a good primary health care system that can effectively treat a variety of physiological conditions. Over two-thirds said that, in theory, they would consider both Western medicine and traditional healing when they fall ill. However, in practice, most of them never consulted traditional healers. This contradiction between the theoretical willingness to consult traditional healers and the practice of not doing so raises questions that cannot be answered by this study. Is it that Western-trained health care practitioners doubt the effectiveness of traditional healing? But if so, why do they then think that traditional healing is a good primary health care system? Are they ashamed to admit that they too consult traditional healers? It has been suggested in the literature that some people consult traditional healers but they do not want to admit this for fear of being looked down upon by others who frown upon traditional healing (Chavunduka, n.d.). Although they 'do not use the services of traditional healers themselves', a large number (75.5% and 79.3% respectively) of health care practitioners said that their friends and relatives do so. Many also have heard of Western-trained health care practitioners who consult traditional healers when they are ill.

These findings are consistent with previous literature wherein the majority of people, particularly black people, have been reported as using traditional healing (King, 2012). However, very few health care practitioners in this study admitted to personally doing so. Therefore, there is a discrepancy between what health care practitioners say they are doing themselves and what they know their communities are doing regarding the usage of traditional healing. This may come about as a result of health care practitioners not wanting other people to know that they also consult traditional healers in their private capacity. One might suspect that because traditional healing is frowned upon by religions such as Christianity, to which the majority of current participants subscribed, as well as being not officially recognised by the HPCSA which regulates the professional conduct of health care practitioners, health care practitioners find it difficult to declare that they too consult traditional healers. Therefore, to try to strike a cognitive balance a large number of health care practitioners resorted to not admitting that they consult traditional healers. A cognitive balance or cognitive consistency is attained when an individual who holds two or more opposing cognitions reduces the tension between them by rejecting one or more of them (Akerlof & Dickens, 1982; Hogg & Vaughan, 2011). In the case of this study, health care practitioners appear to have rejected the idea that they too consult traditional healers.

6.2.2 Do they, or don't they know?

There was a surprising lack of knowledge of traditional healing in the group of Western health care practitioners who participated in the study. In answer to quantitative questions, the majority said, for example, that they did not know, or were unsure about, that there are illnesses in the African tradition that are inflicted by ancestors or through witchcraft; that traditional healers often use plant or animal products to treat illnesses; and that ancestral spirits are the pillars of traditional healing. We might, of course, conclude that if Western-trained health care practitioners indeed never consult traditional healers (see 6.2.1 above) this would explain why they do not have 'enough' knowledge and experience with traditional healing. But there is an interesting contradiction in the findings which clearly indicates ambivalence in the health care practitioners' responses.

Notwithstanding their apparent lack of knowledge of traditional healing, some health care practitioners were very informative in their narratives about what traditional healers can and cannot do. They explained in detail which types of medical conditions could be effectively treated by traditional healers. One of these is sexually transmitted infections, other than HIV and Aids which health care practitioners maintained could not be treated by traditional healers. At least some sexually transmitted infections, and infant rashes, were also mentioned, by nurses in particular, in previous studies as conditions that can effectively be treated by traditional healers (Mngqundaniso & Peltzer, 2008). The WHO also recognises the effectiveness of traditional healing in the treatment of some STIs (Mills et al., 2005).

Health care practitioners who participated in the current study further thought that traditional healers can effectively treat infertility in females, constipation, diarrhea, epilepsy and infant illnesses such as fallen fontanel ('*hlogwana/phogwana*' in *Sepedi*, *Setswana or Sesotho*). They were especially well informed and persistent that fallen fontanel is best treated by traditional healers (who make an incision across the baby's scalp and directly apply medication through the incision) and not by Western-trained doctors who perceive it as a problem of dehydration which can be rectified by rehydrating the baby. Fallen fontanel has always been a controversial condition which many researchers think is culturally-bound although it should be seen as universal but culturally-interpreted (Kay, 1993). In many traditional African communities in South Africa and elsewhere on the African continent, it is often thought that Western medicine does not understand the fallen fontanel condition; hence many people in these communities prefer traditional healing over Western healing in this regard (Moshabela, 2008).

The health care practitioners in the current study were also well informed about the medical conditions that could not be treated by traditional healers, such as HIV, Aids, TB, cardiovascular conditions, any surgical condition, any form of cancer, asthma, diabetes mellitus, hypertension, gangrene, orthopedic conditions, hepatitis B, liver cirrhosis, respiratory conditions and acute abdominal condition. This long list of illnesses may be read as indicating that Western-trained health care practitioners think of traditional healers as having a relatively limited scope of expertise in dealing with illnesses. It might also be an indication of the *perceived causes* of the illness, which in this case is probably linked to the germ theory of causation of illness, with Western-trained health care practitioners being better equipped to deal with the disease. These illnesses are probably not perceived, in traditional healing, as being caused by ancestors or witchcraft, in which case traditional healers are better equipped to deal with the diseases.

Despite their apparent lack of knowledge about traditional healing, the health care practitioners were very well informed about the success with which traditional healers can treat psychiatric conditions such as clinical depression, schizophrenia (*mafofonyane*) or any 'witchcraft-related' psychosis. This was summed up by the responses of one health care practitioner who said that "*my brother in law was a deeply religious person who did not want anything to do with ancestors, but became psychotic and was treated for this, he became much better*". Another participant said that *"most psychiatric patients are bewitched and traditional healers are able to heal them*". Once the condition is perceived as man-made (e.g. witchcraft), traditional healing is often preferred over Western medicine (Hoff & Shapiro, 1986). In such cases, some nurses verbally refer patients to traditional healers without writing the referrals on paper because traditional healing is not formally recognised by the HPCSA (Mngqundaniso & Peltzer, 2008). They do so for patients who are supposedly suffering from man-made illnesses because the traditional healing system tailor-makes the healing process in accordance with the patient's cultural background and their understanding of the condition that they are presenting with (Barsh, 1997). Traditional healing is generally thought to deal effectively with man-made psychiatric conditions better than Western medicine (Odebiyi, 1990; Versola-Russo, 2006).

The discrepancy between the knowledge that health care practitioners displayed in quantitative items and in qualitative items in the questionnaire gives rise to the question as to why this discrepancy exists. The limited knowledge that health care practitioners displayed on the quantitative items might have resulted from their not being willing to admit that they

know a significant amount about traditional healing. Most of the health care practitioners came from communities where the majority of the people use traditional healing. Their displayed lack of knowledge may therefore be a denial of the knowledge of traditional healing that they indeed have.

The better understanding of traditional healing that health care practitioners showed in the qualitative questions indicated that they in fact have much knowledge of traditional healing but that they denied that knowledge in the quantitative items by opting for the 'not sure' option in the questionnaire. This response on numerous occasions may be a sign of their ambivalence of not wanting to admit that they know about traditional healing. It may also indicate that, while they do not want to admit that they know, they also do not want to lie and therefore that they opted for the middle ground: 'I am not sure'. Yet another explanation may be that colonisation and the apartheid system in South Africa taught black people to abandon and cognitively despise their own cultural and traditional practices. The apparent denial of knowledge of traditional healing by black people may therefore be a vestige of the apartheid system in South Africa. During that era, black people were generally ashamed to talk about their cultural practices because these were seen as barbaric, backward and in many instances viewed by Christianity and the Western culture as uncivilized, un-Christian-like and therefore sinful. As a result, many black people were ashamed to openly support traditional healing.

6.2.3 "I support traditional healers, but not openly"

A third of health care practitioners in the study reported that they have very often seen people who were effectively treated by traditional healers. Despite this, only 4.4% actually refer patients to traditional healers. They are probably inclined but hesitant to refer patients to traditional healers because such actions are not sanctioned by the HPCSA (Mngqundaniso & Peltzer, 2008). The inclination to work with traditional healers is evidenced by the many health care practitioners who would like to collaborate with traditional healers (47.3%) by considering referral of patients to traditional healers (62.1%). However, the actual practice of referring patients to traditional healers can only be realised if the HPCSA officially recognises traditional healing, something that many health care practitioners would like to see happen because, as well as the fact that over half of them acknowledging that traditional healing is safe to use and effective in treating many illnesses, the majority are also satisfied with the way traditional healing works. In addition, just under a third of health care practitioners thought that traditional healing is part of people's culture and therefore should

be encouraged. Over a third would like to see a situation where traditional healers are allowed to issue medical certificates to their patients. This indicates that there are many Western-trained health care practitioners who support traditional healing and believe that it is acceptable in their communities.

Western-trained health care practitioners gave different reasons for why they thought that traditional healing was acceptable in the communities they came from. These ranged from the fact that people have a long history of utilising traditional healing, to people being brought up to believe in traditional healing or traditional healing being readily available and effective in treating some conditions that Western medicine seems to fail to treat, such as witchcraft-related psychiatric and physiological illnesses. The issue of people believing in traditional healing because of their cultural upbringing arises in the study by Pinkoane, Greeff and Koen (2008) into policy makers' perceptions and attitudes regarding the incorporation of traditional healing into the national health care system in South Africa. Similar findings were also mentioned in the study by Satimia et al. (1998) that investigated people's choice of modern or traditional health care in rural Tanzania.

However, some health care practitioners in the current study believed that traditional healing was acceptable in their communities for the most part because of those communities' poor education and poverty. This view is shared by Vontress (1991), who asserts that traditional healing is mainly utilised by people who are illiterate. However, Cocks and Dold (2000) argued that traditional healing is utilised by consumers from across the spectrum of education levels.

Notwithstanding the health care practitioners' ambivalence to traditional healing as discussed above, they identified the strengths and weaknesses in traditional healing. They also indicated a way forward for the existence of the two health care systems.

6.2.4 Where to go from here?

The majority of health care practitioners in the current study were of the opinion that traditional healers should improve their practice in certain areas, standardise their training and diagnostics, be more open/transparent about their work, be properly regulated, be held accountable for their practices, improve on personal and general hygiene and learn about cross-infection control, learn to measure correct medication dosages for their patients, learn about the importance of early referral if they cannot effectively treat a condition, and refrain from using renal toxic and hepatotoxic substances in their healing. These and other areas

have already been identified by other researchers as problematic issues in traditional healing (De Beer, 2010; Fennel et al., 2004; Freeman & Motsei, 1992; Green & Makhubu, 1984; Mills et al., 2005; Mngqunadaniso & Peltzer, 2008; Richter, 2003).

While health care practitioners identified several weaknesses or problematic areas in traditional healing, they also identified strengths which they thought that Western medicine could learn from. They thought that Western medicine should learn, in the words of one respondent, "*how to respect and appreciate the perceptions of Africans towards illness, its causes, management and possible outcome – without judgment*". Another respondent said that Western medicine should learn to "*treat community members according to their cultural beliefs, norms and values"*. Others said that traditional healing could teach Western medicine how to use natural herbs in treating conditions such as infertility and how to employ a holistic approach to treatment, treating the mind, body, spirit and the entire family.

These suggestions could be seen as referring to the cultural aspects of ill-health. In other words, illnesses exist within a particular culture, and patients and the illnesses that they present with should be understood within that culture without imposing one's own cultural understanding of illnesses on patients, if different from those of the patients. Some researchers encourage health care practitioners to make an effort to understand their patients' cultural perceptions of illnesses (El Sharkawy et al., 2006). Some illnesses such as schizophrenia ('*mafofonyane'*) are classified by traditional healing as man-made, are complicated and cannot be left to Western medicine alone (Hoff & Shapiro, 1986; Keikelame & Swartz, 2007). Placing illnesses within the relevant cultural milieu is important because culturally unaware medicine can be seen as problematic medicine (Mulato & Berry, 2001). Therefore, health care practitioners need to understand the philosophy underpinning health care in the cultures within which they work.

Although current results indicate significant differences between categories of health care practitioners in terms of their opinions, attitudes, experiences and intentions to work with traditional healers, the majority (over 83% of each category of physicians and general nurses as well as over 92% of psychiatrists and psychiatric nurses) supported the idea of consumers using the health care system of their choice. This implies that although the health care practitioners in this study were trained in Western health care settings (universities and or nursing colleges), subscribed to the germ theory of disease and treatment and, in some cases, did not believe that traditional healing can effectively treat some physical and psychiatric conditions, their responses seem to be in agreement with George Kelly's

philosophy of constructive alternativism which acknowledges that people's realities are different. People construct and reconstruct realities based on experience (Landfield, 1988). In the case of traditional healing and its consumers, their realities in relation to the causes of some illnesses and how to deal with those illnesses is at times different from illness realities of Western medical model. The emphasis here is on the notion of cultural relativism which views people's experiences and interpretations of illness as being culturally dependent. However, it is noteworthy that some constructions and interpretations of reality may be more valid than others. What seems to be critical is that people should constantly evaluate and revise their realities in order to move closer to a more valid construction of reality. In the case of health care, there should be an effort on the part of Western health care system to expose traditional healing system to the Western system and vice versa. The aim should not be to construct one universal reality but rather to better each other's realities by learning from each other. Each health care system should be open to alternative interpretations of realities (McWilliams, 2004). All of these should be done for the benefit of the black consumer, in the African and particularly South African context, who at times is torn between the two health care systems.

Overall, the current findings suggest that medical pluralism, in which consumers have a choice of when to use which medical system, should be encouraged provided that there is clear and open communication between the different health care systems. However, this can still be interpreted as an indication of ambivalence on the part of health care practitioners. With this ambivalence in mind, a critical question is whether health care practitioners would be willing to work with traditional healers?

6.2.5 Would Western-trained health care practitioners be willing to work with traditional healers?

To answer the question of whether Western-trained health care practitioners would be willing to work with traditional healers, the theory of planned behaviour is invoked (Ajzen & Fishbein, 1977; Ajzen & Madden, 1986; Doll & Ajzen, 1992). One aspect of this theory is that of 'volition' (Hogg & Vaughan, 2011), which suggests that prediction of future behaviour can work well if the target behaviour is under the person's control. In the case of the current study, the question is whether the behaviour to work with traditional healers is under health practitioners' control? Some would argue that people tend to have limited control of their behaviour and that this makes it difficult to predict their future behaviour

(Bentler & Speckart, 1979). In the case of health care practitioners, their intentions to work with traditional healers may be influenced by the Department of Health and the Health Professions Council of South Africa (HPCSA). These entities promulgate laws and codes of conduct to regulate the behaviour of health care practitioners in relation to patients. These laws and code of conduct include when and to whom a health care practitioner should refer patients. If, for example, the HPCSA does not recognise traditional healing and the government of the day is ambivalent regarding the formal integration of traditional healing and Western medicine, it would be difficult to reliably measure health care practitioners' intentions to work with traditional healers in the future. The current status quo in South Africa is that Western-trained health care practitioners cannot refer patients to traditional healers unless the HPCSA recognise traditional healers as fellow health care practitioners. Therefore, the target behaviour of Western-trained health care practitioners' intentions to work with traditional healers is not entirely under their control. Future behavioural prediction as set out in this study may have been affected by this, an issue that has an important bearing on the proposed integration of traditional healing and Western medicine.

It emerged in the study that the overwhelming majority of Western-trained health care practitioners would not even share knowledge about good hygiene practices with traditional healers in general, let alone work with them. About half of the health care practitioners showed a willingness to work with traditional birth attendants but not with other types of traditional healers. This may be because the birth attendants do not really prescribe medicines to their patients and therefore do not pose risks in terms of medicine interaction; they work more or less like midwives in a hospital setting.

When data were analysed according to participants' demographics such as gender, religion, language and area (urban or rural) in relation to their opinions, attitudes, knowledge, experiences and intentions to work with traditional healers, a clear pattern emerged. Participants who concurrently practiced both Christianity and traditional African religion had more positive opinions, more positive attitudes, more knowledge, more experiences and were more willing to work with traditional healers than any other group. This may be because traditional healing and traditional African religion are inextricably linked, as the literature suggests (Chavunduka, n.d.; Gumede, 1990a; Nelms & Gorski, 2006). Therefore it is assumed that those who practice traditional African religion would also use traditional healing; hence the current findings.

Despite health care practitioners based in rural areas having more experiences with traditional healing, those based in urban areas had more positive opinions, more positive attitudes and were more willing to work with traditional healers than were those in rural areas. These results are inconsistent with those reported by Upvall (1992), who found that health care practitioners working in urban areas were ambivalent about collaborating with traditional healers. The current results are surprising because one would have thought that since health care practitioners who work in rural areas live in traditional communities, they would be more intimate and comfortable with traditional healing which is more prevalent in traditional communities than in urban communities, and therefore that they would be more willing to work with traditional healers in the future. That was not what this study found. It may be that rural-based health care workers had more negative experiences with traditional healing; hence their reluctance/unwillingness to work with traditional healers in the future.

Moreover, male health care practitioners showed more positive opinions, more positive attitudes, more knowledge and were also more willing to work with traditional healers than were female health care practitioners. It is not clear why male health care practitioners viewed traditional healing in a more positive light than did female health care practitioners. Further research is needed to shed more light on male and female differences in terms of their views of traditional healing.

In summary, mixed findings regarding health care practitioners' views of traditional healing emerged. However, most health care practitioners had moderately favourable opinions of traditional healing and some acknowledged that there are certain conditions such as schizophrenia and fallen fontanel that can be treated by traditional healers. However, they also argued that traditional healers cannot treat conditions such as HIV and Aids, amongst others. They also acknowledged that Western medicine can learn from traditional healing culturally relevant ways of treating some conditions. With moderately favourable opinions of traditional healing, the majority of Western-trained health care practitioners however seem to be reluctant to work with traditional healers in general, except traditional birth attendants, in the future, with psychiatrists and psychiatric nurses being the most welcoming of the idea of working with traditional healers in the future.

6.3 DO DIFFERENT CATEGORIES OF HEALTH CARE PRACTITIONERS HAVE DIFFERENT VIEWS AND EXPERIENCES ABOUT TRADITIONAL HEALING?

Knowing whether different categories of Western-trained health care practitioners have different views or feelings about, and experiences with, traditional healing will assist in assessing which category may be more, or less, willing to work with traditional healers in the future. It will also provide information about where training is needed to bring the other groups on board.

Across the four categories of health care practitioners (psychiatrists, physicians, general nurses and psychiatric nurses), psychiatric nurses emerged as the group with the most positive opinions and attitudes, more knowledge and more experiences with traditional healing than psychiatrists, physicians and general nurses. Psychiatrists had more positive opinions, more positive attitudes and more knowledge than both physicians and general nurses. These findings, particularly about psychiatrists' opinions and attitudes towards traditional healing, are consistent with those of Hopa et al. (1998) who found that psychiatrists further preferred a more formal cooperation with traditional healers. This finding raises the question of why these differences in opinion levels between categories of health care practitioners exist, and in particular why psychiatric nurses and psychiatrists have higher positive opinions of traditional healing than general nurses and physicians. It may be due to the fact that in some universities and colleges the curricula for the training of psychiatrists and psychiatric nurses include comprehensive health care practice that integrates general health, community health and mental health in all contexts of health care delivery (Government Gazette, 2011). An awareness of traditional healing is one of the aspects that are included as part of the comprehensive health care. The inclusion of awareness of traditional healing is in line with Annexure 2 of the Nursing Act number 33 of 2005 which encourages health care practitioners to "*promote and maintain the health status of health care users in all contexts of health care delivery*" (Government Gazette, 2011, p.20).

The fact that psychiatric nurses and psychiatrists have higher positive opinions of traditional healing than general nurses and physicians may also be because traditional healing has been found to be effective in treating psychiatric conditions in some parts of Africa such as central Sudan (Sorketti, Zainal & Habil, 2012). Psychiatrists and psychiatric nurses work with psychiatric issues and this may underlie their more positive opinions, more experience, more positive attitudes and more knowledge of traditional healing. Three South African studies that investigated biomedical and traditional African diagnostics; beliefs and

experiences of consumers of African traditional healing and psychiatric services; and beliefs and experiences of consumers of traditional African healing and community mental health services found that traditional healing provided a significant mental health service in the communities where it is used (Robertson, 2006). On these findings was based the recommendation that collaboration between traditional healing and Western medicine - something that traditional healers, psychiatrists and psychiatric nurses have been doing informally for years - should be urgently encouraged (Hopa et al., 1998). When the two health care systems collaborate, there can be mutual beneficiation between the two (Odebiyi, 1990). In summary, the evidence presented by Sorketti et al. and Robertson's studies may serve as an explanation of why psychiatric nurses and psychiatrists, compared with general nurses and physicians, tend to have more positive opinions, more positive attitudes and more knowledge of traditional healing.

To expand on the above discussion, physicians had less positive opinions and less experience with traditional healing than the rest of the categories of health care practitioners. Hopa et al. (1998) found similar results with physicians going as far as to criticise traditional healers as being illiterate. However, in this study physicians had more positive attitudes towards traditional healing than general nurses. It is not clear why this was the case. Further research is needed to shed more light on this aspect. On the other hand, general nurses' experiences with traditional healing were surpassed only by psychiatric nurses' experiences with traditional healing. This could be explained by the fact that most of the general nurses worked in rural areas, with those who worked in rural areas having slightly more experiences with traditional healing than those who worked in urban areas.

Although some categories of health care practitioners did 'better' than others regarding their experiences with traditional healing, it is worth mentioning that the median scores of all four categories of health care practitioners, in relation to experiences with traditional healing, fell far below the midpoint of 3.This indicated that the four groups did not have much experience with traditional healing. These findings are consistent with Madiba's (2010) findings in which 73% of 60 health care practitioners in Botswana have never interacted with traditional healers. Health care practitioners could improve on their experiences with traditional healing by attending joint workshops and seminars with traditional healers (Mngqundaniso & Peltzer, 2008). Such workshops have been found to result in traditional healers and Western-trained health care practitioners having positive experiences and attitudes towards each other (Hoff & Shapiro, 1986). Western-trained health

care practitioners could also visit traditional healers' consulting rooms to observe how the healers work, something that the majority of Western-trained health care practitioners in this study indicated that they are not likely or are not at all prepared to do. It is possible that such attitudes would be somewhat different, and health care practitioners more prepared to work with traditional healers, if the Government were more supportive and open about their intentions to integrate the two health care systems.

In sum, psychiatric nurses and psychiatrists had more positive opinions, more positive attitudes and more knowledge of traditional healing than physicians and general nurses. However, general nurses' experiences with traditional healing were second to those of psychiatric nurses. By implication, psychiatric nurses and psychiatrists would be more willing to work with traditional healers than would physicians and general nurses. Therefore, if South Africa were to start experimenting with the integration of traditional healing and Western medicine, psychiatric services and institutions could be the best places to start integrating the two health care systems.

6.4 PREDICTORS OF WORKING WITH TRADITIONAL HEALERS IN THE FUTURE

Predicting future behaviour is one of the goals of psychology, and enables the interested parties to formulate policies in line with the predicted behaviour. In the case of the current study, prediction of Western-trained health care practitioners' intentions to work with traditional healers in state hospitals and clinics in the future will assist the government in formulating policy around integration of traditional healing and Western medicine. As the literature suggests, attitudes and opinions determine the potential for the integration of traditional healing and Western medicine (Tabuti et al., 2003).

In this study, attitudes emerged as the strongest predictors of health care practitioners' intentions to work with traditional healers in the future; to a lesser extent, knowledge and opinions were also predictors. Experiences, as measured in this study, did not make a significant contribution in predicting future behaviour, probably because experience with traditional healing in this group was so limited. These findings are inconsistent with those of LaPier (1934), particularly on the question of attitudes as predictors of behaviour. LaPier concluded that attitudes, and particularly social attitudes, cannot be used to reliably predict future behaviour. In the current study, however, health care practitioners' attitudes towards traditional healing emerged as the best predictors of their future behaviour. The difference

between the current study and LaPier's is that the current study did not look at attitudes on the social level, as LaPier did, but rather on the health care services level. Social behaviour and work-related behaviour may be different and therefore the results of the current study can be accepted as valid for work-related behaviour.

In sum, future behaviours can be predicted from knowledge of attitudes. To some extent, knowledge and opinions can also be used to predict future behaviour. However, experiences alone do not seem to enable strong predictions unless they are combined with other variables such as attitudes, knowledge and opinions.

6.5 PRACTICAL IMPLICATIONS FOR INTEGRATION OF TRADITIONAL HEALING AND WESTERN MEDICINE

Western medicine, or modern medicine, was once traditional medicine. It evolved over time to where it is today by, amongst other things, keeping up with the latest technological advancement and research. On the other hand, traditional medicine is called traditional medicine simply because it, by and large, has held on to the ancient ways of dealing with medical conditions, both physiological and psychiatric, and with spiritual conditions. Because of these differences, the two health care systems seem far apart. Yet what could bring them together is each health care system‘s desire and endeavour to prevent and eradicate ill-health and to maintain wellness.

The results of the current study have a number of practical implications for the integration of the two health care systems. First of all, integration would be a mammoth task requiring the concerted effort of political leaders, the Department of Health, higher education institutions that train health care personnel (medical schools and nursing colleges), medical researchers and medical regulatory authorities such as the Health Professions Council of South Africa and the Medicines Control Council (MCC). The strategies to integrate the two health care systems should not only be designed and discussed but should be urgently implemented by the Department of Health, something that the WHO and UNICEF have long been advocating (Green, 2000a; Mngqundaniso & Peltzer, 2008; Peu, Troskie & Hatting, 2001).

Currently the South African government seems to have adopted a cautious attitude of tolerance of traditional healing without formally effecting its inclusion into the primary health care system. At times, the pendulum seems to be swinging without any measurable progress

being made towards the integration, or rejection of the integration, of the two health care systems. On paper, the government supports integration but this is not being effected in practice. At other times, when the government simply says that people should utilise the healing system of their choice, the pendulum seems to be stationary. When this happens, dilemmas are created. Some citizens continue to use both health care systems simultaneously depending on their conceptualisation of their illnesses (Meissner, 2004; Moshabela, Pronyk, Williams, Schneider & Lurie, 2011). This may lead to complications such as organ damage, as some health care practitioners have alluded to in this study, as a result of the interaction of medicines that should not be taken together. This further creates potential problems between medical doctors and traditional healers as there is no space for formal communication between the two, regarding patients.

From the responses on the open-ended questions used in the study, it seems that many health care practitioners have limited knowledge of the physiological conditions that can be treated by traditional healers, with some responses appearing to be dismissive of the efficacy of traditional healing. Some respondents maintained that there were **no** physiological or even psychiatric conditions that could effectively be treated by traditional healers. Others were of the opinion that traditional healing should be **totally discarded** as traditional healers *"are secretive about their work"* and because they often *"are not honest about their own limitations"*. The limited knowledge about traditional healing coupled with dismissive attitudes will make integration of the two health care systems hard to achieve. The limited knowledge and the hard, harsh and disparaging stance against traditional healing can be softened by medical schools and nursing colleges including material on traditional healing in their training of health care personnel, as has been the case in Ghana (Tsey, 1997). The World Health Organization actively discourages disparaging views about traditional healing and instead encourages governments to recruit traditional healers as part of the primary health care system (Bibeau, 1985; Gort, 1989). By implication, even if one does not agree with some aspects of the traditional healing system, one can do so without disrespecting the system in its entirety. In other parts of the world such as in Taiwan, formal cooperation between traditional healing and Western medicine in state health care institutions appears to work relatively well (Kuan et al., 2011).

Some of the respondents in the current study seem to doubt the efficacy of herbal remedies as applied by traditional healers. Given this, it would be difficult to make traditional healing work side-by-side with Western medicine in hospitals and clinics in South Africa.

This calls for medical research to produce recommendations on the medicinal properties of the plant extracts that traditional healers use. Although some plant extracts have already been scientifically tested and proven to be effective treatment for some physiological conditions (Fennell et al., 2004; Gbolade & Adeyemi, 2008; Ndamba et al., 1994; Sofowora, 1996; Sparg et al., 2000), it remains a contentious issue as traditional healers generally do not trust scientists and pharmaceutical companies with their knowledge of herbs. Often traditional healers say that Western scientists plagiarise their ideas, modify them, repackage them and sell them in the form of medicinal drugs as 'new discoveries' (Meissner, 2004). This calls for the relevant authorities to actively start protecting the intellectual property rights of traditional healers (Nyika, 2007).

Health care practitioners in this study heavily criticised traditional healing for the lack of a regulatory authority to register bona fide traditional healers and regulate their professional conduct so that traditional healers can start taking responsibility and being accountable for their professional conduct. Health care practitioners have leveled similar criticisms against traditional healers in previous studies (Hopa et al., 1998; Mngqundaniso & Peltzer, 2008). As things stand, some Western-trained health care practitioners find it difficult to even think of collaborating with traditional healers. This issue requires organisations such as the Health Practitioners Council of South Africa (HPCSA) and the Traditional Healers Organisation to start working together to chart a way forward if the two health care systems are to be integrated. Integration of the two systems should be treated as a matter of urgency to benefit patients in particular (Edginton et al., 2002). However, it appears that the situation of medical pluralism in which there is no formal cooperation between the health care systems will persist for many decades to come (Green, 1988; Moshabela et al., 2011).

6.6 SUGGESTIONS FOR COLLABORATION BETWEEN TRADITIONAL HEALING AND WESTERN MEDICINE

Traditional healing and Western medicine have been operating independent of each other, in South Africa, for many centuries. This separation does not appear to be doing justice to health care in South Africa. There are many obstacles to the integration of traditional healing and Western medicine in state health care institutions. The following suggestions are presented that might pave the way for integration of the two health care systems, bearing in mind that psychiatric institutions could be the best places to pilot the proposed integration:

- Medical schools and nursing colleges should consider including a short course on traditional healing in their programmes. It could be taught by qualified traditional healers recognised by traditional healers' organisations. In South Africa and elsewhere on the African continent, there are traditional healers who have doctoral degrees and other formal qualifications. Such professionals could be recruited in medical schools and nursing colleges to teach short courses on traditional healing. The idea is not to turn Western-trained medical practitioners into traditional healers but rather to open up the traditional healing discipline so that medical practitioners and nurses can have a better understanding of traditional healing.
- Medical schools and nursing colleges should also consider offering short courses for traditional healers on general medical and nursing issues such as hygiene and cross-infection control. This would address criticisms regarding unhygienic practices that were leveled at traditional healers by health care practitioners in this study. It could also be an opportunity to teach traditional healers about HIV, Aids and proper surgical procedures for circumcision. This kind of intervention could go a long way in lessening the spread of HIV and Aids since the majority of people enlist the services of traditional healers. After completing the course, traditional healers could be used as a resource to help prevent the spread of HIV and other sexually transmitted infections, and to treat some HIV-related conditions. Knowledge can also be shared between traditional healers and Western medical practitioners on how and when to refer patients to appropriate health care providers.
- At the clinic or hospital level, nurses and doctors should be encouraged to have regular workshops or conferences with traditional healers so that health care knowledge can be shared between the two health care systems. Western-trained health care practitioners should be given reading material on traditional healing so that they are familiar with various aspects of traditional healing. The WHO's suggestions on traditional healing should be made available to Western-trained health care practitioners in clinics and hospitals.
- The proposals to integrate the two health care systems should be thoroughly interrogated and acted upon by other bodies such as institutions that train health care practitioners, Health Professions Council of South Africa, Medicines Control Council, Medical Research Council and traditional healer organisations.

In sum, a considerable amount still needs to be done by many relevant bodies before integration of the two health care systems can be attempted in South Africa.

6.7 LIMITATIONS OF THE STUDY

The present study has realised its aims. Ideally, the study would have obtained equal or almost equal number of participants in each category of health care practitioners: general nurses, psychiatric nurses, physicians and psychiatrists. The skewness and relatively small number of participants in some categories such as psychiatrists and physicians may have compromised the power of some statistical techniques such as the Kruskal-Wallis Test and standard multiple regression analyses. Nonetheless, the skewness of data in the current study simply reflects the skewness of distribution of categories of health care practitioners in the South African public health care sector; there are far more general nurses than there are other categories of health care practitioners in the sector. The results of this study should therefore be read with that skewness of distribution in mind.

Another limitation was perhaps the length of the questionnaire used in the study. Although it was largely quantitative, some respondents may have felt that it was too long. After completing the questionnaire, one respondent remarked in writing on the questionnaire that "*this questionnaire was too much*". This was also the feedback that the researcher got from talking to some hospital and clinic personnel as well as the research assistants' reflections on data collection. Despite this limitation, questionnaires were filled in well and without much missing data.

A third limitation may have been in the questionnaire itself. The use of "*not sure*" as a response option may have affected the quality of some responses; one might opt for this response set if one does not want to think long and hard about one's response to the item. This is a difficult issue, as a researcher may not know if respondents were genuinely 'not sure' when they opted for this response option. In some cases, however, the value of the *"not sure"* option chosen by some health care practitioners should not be disregarded because, as was probably the case with knowledge, it reflected the feelings of ambivalence between *"I have the knowledge"* but *"I am not comfortable to share the fact that I have the knowledge".*

The fourth limitation may be the fact that the study did not include measures of 'subjective norms' to predict future behaviour. Subjective norms refer to perceptions of the beliefs and values of significant others, and perhaps also of significant organisations (Fredricks & Dosset, 1983). In the current study, significant others would refer to health care

practitioners' friends, relatives, the health care institutions that they work for and the professional organisations to which they belong. The beliefs and values of significant others may have an influence on how health care practitioners behave towards traditional healing. By implication, similar research to the current work would do better to include more measures of subjective norms as predictors of health care practitioners' future behaviour towards traditional healing.

The fifth limitation was the fact that the study was a one way process in which only Western-trained health care practitioners' views on traditional healing were looked at. To make recommendation for the integration of traditional healing and Western medicine, it would also be necessary to investigate traditional healers' views on Western medicine.

Finally, the study does not pretend to have drawn on a representative sample of health care practitioners in South Africa. The results of the study may therefore have only internal validity and not be capable of extrapolation across the entire state health care sector.

6.8 RECOMMENDATIONS FOR FUTURE RESEARCH

The current study has laid a foundation for the South African Department of Health to carry out similar studies in the future. The study was limited to relatively few hospitals and clinics in only two provinces. The Department of Health could do well by commissioning a nationwide study that would include most clinics and hospitals. This would give the Department a reference point when formulating policies around the integration of traditional healing and Western healing models. Further studies should also be done by including traditional healers' views on Western medicine. This will enable researchers to have a better idea when arguing for or against integration of traditional healing and Western medicine. In addition, researchers should continue to study the medicinal properties of plant extracts used by traditional healers. This kind of research should be supported by the HPCSA, the Department of Health, the Medical Research Council, the Medicines Control Council, Traditional Healers Organisations and other relevant bodies.

Within the study, there was overrepresentation of general nurses working in rural areas and speaking Sepedi as their home language. In future research, an attempt should be made to balance this by drawing on more general nurses with other South African languages as home languages and working in urban hospitals and clinics.

6.9 CONCLUSION

This study examined health care practitioners' intentions to work with traditional healers by investigating their opinions, attitudes, knowledge, and experiences with traditional healing. It looked at vital differences between four categories of Western-trained health care practitioners in the public sector in terms of their views, contradictory in many instances, of traditional healing. The study also touched on the importance of prediction of future behavioural intentions in order to guide the proposed integration of traditional healing and Western medicine in South Africa. It would appear that the current potential to integrate the two health care models is remote and can only be realised with considerable effort from all stakeholders. Otherwise, South Africa may still be talking about 'possible' integration of traditional healing and Western healing for many years to come.

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APPENDICES

APPENDIXA: PERMISSION TO CONDUCT RESEARCH FROM THE MEDICAL ADVISORY COMMITTEE

Date: 04 May 2011

TITLE OF PROJECT: Perceptions and attitudes towards traditional African healing: implications for integration of traditional African and Western health care models

UNIVERSITY: UNISA

Principal Investigator Mr Maboe Mokgobi

Department: Psychology

Supervisor (If relevant): Prof A Van Dyk

Permission Head of Department (where research conducted) in a number of different departments

Date of start of proposed study: January 2011

Date of completion of data collection December 2011

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO /management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:-

- The research assistant used in this study should only be involved outside of his/her normal working hours. The study should not interfere with their normal hospital activities and permission for the research assistant to be involved in the study should be obtained from the supervisor and the relevant Senior Clinical Executive.
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- the MAC will be informed of any serious adverse events as soon as they occur
- permission is granted for the duration of the Ethics Committee approval.

PROF JOHN PETTIFOR
MBBCh, FCP(S.A.)
CHIEF PAEDIATRICIAN

APPENDIX A: PERMISSION TO CONDUCT RESEARCH FROM THE MEDICAL ADVISORY COMMITTEE (continued)

STUDY: PERCEPTIONS AND ATIITUDES TOWARDS TRADITIONAL AFRICAN HALING: IMPLICATIONS FOR INTEGRATION OF TRADITIONAL AFRICAN WESTERN HEALTH CARE MODELS_*

Permission has been granted that you may use Sterkfontein Hospital as a site for the above research. However, since this is a research project involving voluntary participation, we cannot guarantee participation of staff.

Please contact Mrs. Hannie Smit at (011) 951-

8341 during office hours for assistance.

Thank you.

DR. U. SUBRAMANEY

PRINCIPAL PSYCHIATRIST *I* CLINICAL HEAD

APPENDIX B: REQUEST FOR PERMISSION TO DO A STUDY AT WESKOPPIES HOSPITAL

Maboe Mokgobi <maboe.mokgobi@monash.edu> 11 January 2011 09:56
To: Ronel. Ludick@gauteng.gov.za

Hi Ronel,

Happy new year. I am kindly inquiring about the status of my application to do research at Weskoppies

Hospital. I have not heard anything from the hospital, as yet. could you please advise me on what to do next.

Sincerely

Maboe Mokgobi

Dear Ronel,

Please receive my application as per our short telephonic discussion this morning.

Sincerely

Maboe Mokgobi

Ludick, Ronel R.(GPHEALTH) <Ronei.Ludick@gauteng.gov.za>

To: Maboe Mokgobi <maboe.mokgobi@monash.edu>

Dear Maboe

17 January 2011 10:00

Your name is currently placed on the waiting list; you will be informed as soon as there is an opening.

Ronel Ludick
PA to the CEO of Weskoppies Hospital
Training and Development Coordinator
Tel: +27 12 319 9799
Fax: +27 12 327 7076

APPENDIX C: STUDY PERMISSION FROM DoH, LIMPOPO PROVINCE

LIMPO PO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

Enquiries: Selamolela Donald

Ref: 4/2/2

07 February 2011
Mokgobi M
Monash South Africa
Roodepoort
1725

Dear Sir

Re: Permission to conduct the study titled: Perceptions and attitudes towards traditional African healing: Implications for integration of traditional African and Western health care models.

1. The above matter refers.
2. The permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should not be any action that will disrupt the services
   - After completion of the study, a copy should be submitted to the Department to serves as a resource

APPENDIX C: STUDY PERMISSION FROM DoH, LIMPOPO PROVINCE (continued)

- The researcher should be prepared to assist in the interpretation and implementation of study recommendation where possible

Your cooperation will be highly appreciated

Head of Department
Health and Social Development
Limpopo Province

Private Bag x 9302
Polokwane.
18 College Str. Polokwane 0700. Tel.:(015) 293 6000 Fax: (015) 293 6211
Website: http/www.limpopo.gov.za

APPENDIX D: A COVERING LETTER FOR QUESTIONNAIRES

School of Health Sciences

Title of the study: Perceptions and attitudes towards traditional healing: Implications for integration of traditional healing and Western healing.

My name is Maboe Mokgobi. I am a lecturer in the School of Health Sciences at Monash South Africa (a campus of Monash University Australia). I am also a doctoral candidate at UNISA. My doctoral research is on Western-trained health care practitioners' perceptions and attitudes towards traditional healing. Therefore, participants in this study should be medical practitioners and nurses.

This study is informed by the ongoing debate in the health care sector about the possible integration of traditional healing and Western healing in State hospitals and clinics in South Africa. Therefore, your participation in this study is highly valued and much appreciated as it adds to the knowledge pool in the area of the integration of the two health care systems.

The current study utilises a questionnaire to collect data and participation is voluntary. The data that will be collected will be totally anonymous. Participants can stop participating if and when they feel uncomfortable to continue to be part of this study. The questionnaire is divided into four parts and participants are kindly asked to complete all four parts. It takes about 30 minutes to complete the entire questionnaire. After completing the questionnaire please return the completed copy to the research assistant who is stationed in your institution.

If you have any query or just want to chat about the study or questionnaire please do not hesitate to contact me. My mobile number and e-mail address are listed below.

Thank you very much for your valued participation

Maboe Mokgobi (Mobile number……)

Maboe.mokgobi@monash.edu

APPENDIX E: THE VIEWS ON TRADITIONAL HEALING QUESTIONNAIRE (VTHQ)

PART 1: DEMOGRAPHIC DATA

Please mark the appropriate category or write the answer in words or numbers where asked.

A. What is your Gender : 1. Male 2. Female

B. What is your age in years ……

C. What is your designated role in this hospital/clinic?

1. Psychiatrist
2. Physician
3. General nurse
4. Psychiatric nurse

D. **Number of Years in this designated role** ……..

E. **What is your religion:**

1. Christian 2. Traditional African 3. Both Christian & Traditional African 4. African Independent (E.g. ZCC, Shembe, Apostolic, etc) 5. Other (please specify) 6. Not Religious

F. What is your home Language

1. Sepedi 2. Zulu 3. Xhosa
4. Tsonga 5. Venda 6. English
7. Afrikaans 8. Setswana 9. Sesotho
10. Ndebele 11. Other (please specify) ……

G. **Hospital/Clinic setting** (a) Rural area

(b) Urban area

PART 2: This section asks about your experiences with traditional (African) healing. Please tick ONE box only on a scale of 1-5 (1 = STRONGLY AGREE; 2 = AGREE; 3 = NOT SURE; 4 = DISAGREE; 5 = STRONGLY DISAGREE)

1. I want to learn more about traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

2. Traditional healing belongs in the olden days.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

3. Traditional healing is here to stay.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

4. Integration of traditional healing and Western healing will not work.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

5. Traditional healing is a good primary health care system.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

6. Medical aid schemes should not recognize traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

7. Traditional healing is important for maintenance of health.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

8. Traditional healing should continue to be totally separate from Western healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

9. I would consider consulting a traditional healer in the future.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

10. Traditional healing cannot be trusted.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

11. When I have a physical illness I consider both traditional healing and Western healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

12. The Western health care system and traditional health care system could improve health if they worked together.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

13. I would not encourage anybody to use traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

14. People should use the healing system of their choice.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

15. I would never use traditional healing for any reason.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

16. I do not know how I feel about traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

17. Traditional healing is part of the people's culture and therefore should be encouraged.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

18. If proper regulation of traditional healing can be attained, traditional healing would be a good system.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

19. When people are ill, they should see Western-trained medical practitioners and not traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

20. I do not want to learn anything about traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

21. Traditional healing is safe to use.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

22. If given an opportunity, I would collaborate with traditional healers in treating patients.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

23. Traditional healing should be discarded.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

24. Traditional healing can effectively treat psychiatric conditions just like Western healing does.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

25. Traditional healing is acceptable.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

26. I would support the integration of traditional healing and Western healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

27. Traditional healing is effective in treating physiological conditions such as epilepsy.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

28. Traditional healing is effective in treating psychiatric conditions such as schizophrenia (*mafofonyane*).

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

29. The government is doing well by supporting traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

30. I would consider referring patients to traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

31. Training of traditional healers is adequate.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

32. Traditional healing in South Africa is well regulated.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

33. Traditional healers should be allowed to issue medical certificates/sick leave certificates to their patients.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

34. Traditional healers should be formally recognized by the Health Professions Council of South Africa.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

35. I Would seek help from traditional healers even when Western medicine is available.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

36. Traditional healing is dangerous.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

37. Traditional healing has an important role to play in South Africa.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

38. The World Health Organization (WHO) encourages traditional healing as a primary health care system.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

39. In South Africa, there are hospitals and clinics that collaborate with traditional healers in one way or another.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

40. In South Africa, there are more traditional healers than Western medical practitioners.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

41. There are some Christians who consult traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

42. Approximately 80% of black people in South Africa use the services of traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

43. Traditional healing uses both animal and plant products as well as mineral substances to treat illnesses.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

44. In traditional healing, patients' cultural beliefs of health and illness are used along with physical, social, and spiritual data to make a diagnosis.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

45. In traditional healing, there are illnesses that are believed to be inflicted by the ancestors.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

46. In traditional healing, there are illnesses that are believed to be caused by witchcraft or sorcery.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

47. Some traditional healers are Christians.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

48. Ancestral spirits are the pillars of traditional healing.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

49. Traditional healing is more holistic in its approach than the Western healing (i.e traditional healing treats the body, mind and spirit).

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

50. ANYBODY can be trained to become a traditional healer.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

51. There are physiological conditions that can be treated by traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

52. If you Strongly Agreed or Agreed with the statement above, please mention physiological conditions that you know can be treated by traditional healers.

……

……

53. There are psychiatric conditions that can be treated by traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

54. If you Strongly Agreed or Agreed with the statement above, please mention any psychiatric conditions that you know can be treated by traditional healers

……

……

55. There are conditions that cannot be treated by traditional healers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

56. If you Strongly Agreed or Agreed with the statement above, please mention any conditions that you know cannot be treated by traditional healers

……

……

57.Traditional healing cannot be separated from traditional African religion.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

58. One has to be trained to qualify as a traditional healer.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

59. If you Strongly Agreed or Agreed with the statement above, could you please tell us

Who trains traditional healers?

……

……

60.Traditional healing is accepted by my community.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

61. If you Strongly Agreed or Agreed with the statement above, what is/are the main

reason/s for the acceptance of traditional healing by your community?

……

……

62.Traditional healing needs improvement.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

63. If you Strongly Agreed or Agreed with the above statement, please mention any

area/s where you think traditional healing needs some improvement.

……

……

64.Traditional healers are important primary health care providers.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

65. I find traditional healers to be secretive about their work.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

66. Western healing system can learn from traditional healing system.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

67. If you Strongly Agreed or Agreed with the statement above, please state what it is that Western healing can learn from traditional healing.

……

……

68.I am satisfied with the way traditional healing works.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

69. My experience with traditional healing is limited.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

PART 3: For the next set of questions please tick ONE box only on a scale of 1-5 (1 = NEVER; 2 = SELDOM; 3 = OFTEN; 4 = REGULARLY; 5 = ALWAYS).

1. How often do you consult a traditional healer?

Never	Seldom	Often	Regularly	Always

2. How often do you have patients who consulted Western-trained health care practitioners soon after consulting traditional healers?

Never	Seldom	Often	Regularly	Always

3. I have consulted traditional healers before I qualified as a health care practitioner.

Never	Seldom	Often	Regularly	Always

4. I have consulted traditional healers after I qualified as a health care practitioner.

Never	Seldom	Often	Regularly	Always

5. Some of my friends consult traditional healers.

Never	Seldom	Often	Regularly	Always

6. Some of my relatives consult traditional healers.

Never	Seldom	Often	Regularly	Always

7. I have treated patients who were referred by traditional healers.

Never	Seldom	Often	Regularly	Always

8. I do refer patients to traditional healers.

Never	Seldom	Often	Regularly	Always

9. How often do traditional healers share their knowledge about health care with you (i.e in the form of workshops, seminars, one-on-one conversation, etc).

Never	Seldom	Often	Regularly	Always

10. Traditional healing is used by my community.

Never	Seldom	Often	Regularly	Always

11. Have you, personally, ever come across harmful traditional healer practices.

Never	Seldom	Often	Regularly	Always

12. Do you ever ask your patients whether they have consulted traditional healers before consulting you?

Never	Seldom	Often	Regularly	Always

13. I have seen patients who were effectively treated by traditional healers.

Never	Seldom	Often	Regularly	Always

14. I have heard of Western-trained health care practitioners who consult traditional healers when they are ill.

Never	Seldom	Often	Regularly	Always

15. I have heard of Western-trained health care practitioners who consult traditional healers for reasons other than illness.

Never	Seldom	Often	Regularly	Always

Part 4: For the following set of questions please tick ONE box only on a scale of 1-5 (1 = Absolutely; 2 = Maybe; 3 = Unsure; 4 = Not likely; 5 = Not at all)

1. **I would encourage people to consult traditional healers.**

Absolutely	Maybe	Unsure	Not likely	Not at all

2. **I would refer patients to traditional healers.**

Absolutely	Maybe	Not sure	Not likely	Not at all

3. **I am prepared to work with a diviner** (a traditional healer who uses bones and spirit of the ancestors to make a diagnosis and to prescribe medication).

Absolutely	Maybe	Not sure	Not likely	Not at all

4. **I am prepared to work with a Sanusi/Sedupe** (a traditional healer who can foretell the future).

Absolutely	Maybe	Not sure	Not likely	Not at all

5. **I am prepared to work with a traditional surgeon** (e.g a traditional healer who performs circumcision on boys).

Absolutely	Maybe	Not sure	Not likely	Not at all

6. **I am prepared to work with a traditional birth attendant** (one who has perfected the skill of midwifery).

Absolutely	Maybe	Not sure	Not likely	Not at all

7. **If I had my way, I would have traditional healers employed in every state clinic or hospital in South Africa.**

Absolutely	Maybe	Not sure	Not likely	Not at all

8. **I would encourage other health care practitioners to learn more about traditional healing.**

Absolutely	Maybe	Not sure	Not likely	Not at all

9. **I would like to share knowledge about hygiene with traditional healers.**

Absolutely	Maybe	Not sure	Not likely	Not at all

10. **I would like to attend joint workshops/discussions with traditional healers.**

Absolutely	Maybe	Not sure	Not likely	Not at all

11. **I would only collaborate with traditional healers if they are properly regulated by the state.**

Absolutely	Maybe	Not sure	Not likely	Not at all

12. **I am prepared to visit traditional healers' consulting rooms just to observe how traditional healers work.**

Absolutely	Maybe	Not sure	Not likely	Not at all

13. **I am prepared to support the integration of traditional healing with Western medicine.**

Absolutely	Maybe	Not sure	Not likely	Not at all

Thank you very much for your participation

APPENDIX F: PRINCIPAL COMPONENT ANALYSIS SCREE PLOT