STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

by

NOMAZWI MAUDLINE TEMBANI

Submitted in fulfillment of the requirements for the degree of

DOCTOR CURATIONIS

IN THE FACULTY OF HEALTH SCIENCES

at the

NELSON MANDELA METROPOLITAN UNIVERSITY

Promoter: Prof. R M. Van Rooyen
Co-promoter: Dr B. Pretorius

JANUARY 2009
DEDICATION

This study is dedicated to the Tembani-Ngculu families (amaZotsho akwaMsali, Gadluma, Cekwane) and Nomnganga family (amaZizi akwaDlamini, Jama, Sijadu).
ACKNOWLEDGEMENTS

To my Creator, the pillar of my life: Uyintonina umntu le nto umkhathaleleyo?

My appreciation goes to the following persons as without their contribution this study would not have materialised:

- My promoter, Professor R.M. Dalena Van Rooyen and co-promoter, Doctor Blanche Pretorious. The super skills they displayed in guiding, supporting and motivating me are highly appreciated. They overstretched their patience in persuading me to go on when I was almost giving up.
- Mrs Rosemary Batchelor for editing my work.
- Mrs Redène Vermaak for the technical lay-out of the study.
- Doctor Thembi Norushe who acted as the Independent Coder.
- Nomfundiso Mtyeku for keeping me up-dated about issues relating to traditional healing and making it possible for me to attend conferences and rituals on traditional healing as part of participant observation.
- Mr Solly Nduku for providing insight on processes leading to legalisation of traditional healers in South Africa.
- My friends: Girlie Yekani, Sweetlina Ngowapi, Zandile Mfunda, Nomthandazo Gwabeni and Nonkululeko Hoko for the moral support provided throughout this tedious journey.
- Finally to the entire Tembani family especially my sister Nonkulu Jiya, my two daughters Roundy and Onzy and my grandson Sifiso for supporting me.
The following institutions and persons are also acknowledged:

- The Eastern Cape Department of Health for allowing me to undertake the study.
- Nelson Mandela Metropolitan University for the financial assistance for the first two years of my study.
- The manager of SS Gida hospital, Mrs Nosiphiwo Dubula.
- All the participants especially traditional health practitioners, Camagu!
ABSTRACT

The formal recognition of traditional healing has been controversial for some time with traditional healers being labelled by those of conventional medical orientation as a medical hazard and purveyors of superstition.

The support for the development of traditional medicine and establishment of cooperation between traditional healers and allopathic health practitioners was first promoted in the international health arena by the World Health Organisation. Estimating that 80% of the population living in rural areas of many developing countries was using traditional medicine for the primary healthcare needs, this organisation advocated for the establishment of mechanisms that would facilitate strong cooperation between traditional healers, scientists and clinicians.

The study was undertaken in the Amathole District Municipality, Province of the Eastern Cape based on Chapter 2, Section 6(2) (a) of the Traditional Health Practitioners Bill 2003, which required regulation and promotion of liaison between traditional health practitioners and other health professionals registered under any law. The purpose of the study was to develop and propose strategies to facilitate collaboration between traditional and allopathic health practitioners to optimise and complement healthcare delivery.

The conceptual framework guiding the study was derived from Leininger's theory of Cultural Care Diversity and Universality chosen because of its appropriateness. The terms used throughout the study were defined to facilitate the reader's understanding. Ethical principles were adhered to throughout the research process. To ensure trustworthiness of the study, Guba's model (in Krefting,1991:214-215) was used where the four aspects of trustworthiness namely, truth value, applicability, consistency and neutrality were considered.

A qualitative, exploratory, descriptive and contextual research design was used which assisted in articulating the appropriate strategies to develop to facilitate
collaboration between allopathic and traditional health practitioners. The study was done in two phases. Phase one entailed data collection using unstructured interviews, a focus group interview, literature control and modified participant observation. In Phase two strategies to facilitate collaboration between allopathic and traditional health practitioners were developed. The population in this study comprised three groups of participants. Group 1 consisted of allopathic health practitioners, Group 2 comprised traditional healers and Group 3 was composed of participants who were trained as both traditional healers and allopathic health practitioners.

All participants had to respond to three research questions which aimed at:

- exploring and describing the nature of the relationship between allopathic and traditional health practitioners before legalisation of traditional healing and their experience as role-players in the healthcare delivery landscape in the Amathole District Municipality.
- eliciting the viewpoints of allopathic and traditional health practitioners regarding the impact on their practices of legalisation of traditional healing and
- developing strategies to facilitate collaboration between allopathic and traditional health practitioners.

Data obtained from each group was analysed using Tesch’s method as described by Creswell (2003:192). Themes emerging from data and the corresponding strategies to address the themes were identified for each group. The participants’ responses to the three research questions revealed areas of convergence and divergence. Of significance was the reflection by the participants on their negative attitude towards each other. They also highlighted that there was no formal interaction between traditional and allopathic health practitioners in the Amathole District Municipality. Their working relationship was characterised by a one-sided referral system with traditional healers referring patients to allopathic health practitioners but this seemed not to be reciprocated
by the latter group. The exception was the case of traditional surgeons whose working relationship with allopathic health practitioners was formally outlined in the Application of Health Standards in the Traditional Circumcision Act, Act No.6 of 2001. Allopathic health practitioners attributed their negative attitude as emanating from the unscientific methods used by traditional healers in treating patients, interference of traditional healers with the efficacy of hospital treatments and delays by traditional healers in referring patients to the hospitals and clinics. Traditional healers stated that they were concerned about failure of allopathic health practitioners to refer patients who talked about “thikoloshe” and “mafufunyana” to the traditional healers. Consequently, these patients presented themselves to the traditional healers when the illness was at an advanced stage. A reciprocal referral system was perceived by the traditional healers as the core element or crux of collaboration.

There were ambivalent views regarding the impact of legalisation of traditional healing on the practices of both traditional and allopathic health practitioners. Elimination of unscrupulous healers, economic benefits, and occupational protection were benefits anticipated by traditional healers from the implementation of the Act. The possibility of having to divulge information regarding their traditional medicines, monitoring of their practice resulting in arrests should errors occur were however, cited by traditional healers as threatening elements of the Act.

A lack of understanding the activities of each group with an inherent element of mistrust became evident from the participants’ responses. Ways of fostering mutual understanding between them were suggested which included holding meetings together to discuss issues relating to healing of patients, exposing both groups of health practitioners to research, as well as training and development activities. The participants also highlighted areas of collaboration as sharing resources namely, budget, physical facilities, equipment and information and role clarification especially pertaining to disease management. The participants
strongly suggested that there should be clarity on the type of diseases to be handled by each group. The need for capacity building of traditional and allopathic health practitioners in preparation for facilitating collaboration was advocated by all and the relevant activities to engage into were suggested.

Analysis, synthesis and cross referencing of the themes that emerged from the data culminated in the identification of three strategies that were applicable to all groups of participants and which would assist in facilitating collaboration between allopathic and traditional health practitioners. The researcher coined the three strategies “Triple C” strategies abbreviated as the TRIC strategies. The first “C” of the three “Cs” stands for “change attitude”, the second “C” for “communication” and the third “C” for “capacity building.”

Each of the proposed three strategies is discussed under the following headings:-

- Summary of findings informing the strategy
- Theory articulating the strategy
- Aim of the strategy
- Suggested implementation mechanism

As the strategies had to be grounded in a theory which would serve as a reference point, the researcher used the Survey List by Dickoff, James and Wiedenbach (1968:423) as a conceptual framework on which to base the proposed three strategies.

The results of this study and recommendations that have been made will be disseminated in professional journals, research conferences and seminars.

**Key words**: strategies, collaboration, traditional healer, allopathic health practitioner.
# TABLE OF CONTENTS

Dedication ......................................................................................................................... i
Acknowledgements ............................................................................................................. ii
Abstract ............................................................................................................................... iv

## CHAPTER 1: OVERVIEW OF THE STUDY ............................................................. 1

1.1 INTRODUCTION AND BACKGROUND ................................................... 1
1.2 PROBLEM STATEMENT ........................................................................... 12
1.3 RESEARCH QUESTIONS ........................................................................ 13
1.4 PURPOSE AND OBJECTIVES OF THE STUDY ..................................... 14
  1.4.1 Purpose of the study ........................................................................... 14
  1.4.2 Objectives .......................................................................................... 14
1.5 RELEVANCE OF THE STUDY ................................................................. 14
1.6 CONCEPTUAL FRAMEWORK ................................................................ 16
1.7 CONTEXTUAL CONCEPT CLARIFICATION ........................................ 19
1.8 RESEARCH DESIGN AND METHODS .................................................. 22
  1.8.1 Research Design ................................................................................ 22
  1.8.2 Research Method .............................................................................. 24
    1.8.2.1 Phase One: Data gathering and analysis .................................... 24
    1.8.2.1.1 Research Population ............................................................... 24
    1.8.2.1.2 Data Collection Methods ....................................................... 25
    1.8.2.1.3 Pilot Study .............................................................................. 26
    1.8.2.1.4 Data Analysis ...................................................................... 26
1.9 LITERATURE CONTROL ....................................................................... 26
1.10 PHASE 2: DEVELOPING STRATEGIES TO FACILITATE ... 27
    COLLABORATION ................................................................................ 27
1.11 TRUSTWORTHINESS OF THE STUDY .................................................. 27
1.12 ETHICAL CONSIDERATIONS ................................................................. 28
1.13 CHAPTER LAYOUT ............................................................................. 28
1.14 CHAPTER SUMMARY ........................................................................ 28
CHAPTER 2: RESEARCH DESIGN AND METHODS ........................................... 30

2.1 INTRODUCTION ..................................................................................... 30

2.2 RATIONALE ............................................................................................. 30

2.3 OBJECTIVES OF THE STUDY ................................................................. 31

2.4 RESEARCH DESIGN AND METHODS .................................................... 32

2.5 RESEARCH METHODS ............................................................................ 36

2.5.1 Phase 1: Data gathering and analysis ................................................. 37

2.5.1.1 Research Population ................................................................. 37

2.5.1.2 Group 1: Allopathic health practitioners ........................................ 38

  Sampling method ................................................................................. 38

  Data-collection method ....................................................................... 40

  Data Analysis ....................................................................................... 46

  Group 1a: Allopathic health practitioners belonging to other health fields 49

  Sampling method ................................................................................. 50

  Data collection method ....................................................................... 50

  Data analysis ....................................................................................... 50

2.5.1.3 Group 2: Traditional healers ......................................................... 51

  Sampling method ................................................................................. 51

  Data-collection method ....................................................................... 53

  Data Analysis ....................................................................................... 64

2.5.1.4 Group 3: Nurses who are also traditional healers .......................... 65

  Sampling Method ............................................................................... 65

  Data collection method ....................................................................... 66

  Data Analysis ....................................................................................... 68

2.5.1.5 Pilot Study ...................................................................................... 68

2.5.1.6 Literature Control .......................................................................... 68

2.5.2 Phase 2: Developing strategies to facilitate collaboration between

  allopathic and traditional health practitioners ....................................... 69

2.6. TRUSTWORTHINESS OF THE STUDY ................................................. 70

2.7 ETHICAL CONSIDERATIONS .................................................................. 77

2.8 CHAPTER SUMMARY .............................................................................. 79
CHAPTER 3: DISCUSSION OF FINDINGS AND LITERATURE

3.1 INTRODUCTION ................................................................. 80
3.2 RESEARCH FINDINGS ...................................................... 80

3.2.1 FINDINGS FROM GROUP 1: ALLOPATHIC HEALTH PRACTITIONERS ........................................... 81
  3.2.1.1 Theme 1: Allopathic health practitioners reflected on their negative attitude towards traditional health practitioners ........................................ 85
  3.2.1.2 Theme 2: Allopathic health practitioners acknowledged that they lacked knowledge about the new Traditional Health Practitioners Act .............................................................. 94
  3.2.1.3 Theme 3: Allopathic health practitioners suggested that mutual understanding was crucial to the effective collaboration between traditional and allopathic health practitioners ........................................ 96

3.2.2 FINDINGS FROM GROUP 1a: ALLOPATHIC HEALTH PRACTITIONERS BELONGING TO OTHER HEALTH FIELDS .... 106

3.2.3 FINDINGS FROM GROUP 2: TRADITIONAL HEALTH PRACTITIONERS ........................................... 108
  3.2.3.1 Theme 1: Traditional health practitioners experienced a relationship with allopathic health practitioners that was characterised by a one-sided referral system ........................................ 112
  3.2.3.2 Theme 2: The new Traditional Health Practitioners Act was perceived by traditional healers as having both beneficial and threatening elements related to their practices ........................................ 119
  3.2.3.3 Theme 3: Traditional health practitioners suggested possible areas of collaboration .............................................................. 131

3.2.4 FINDINGS FROM GROUP 3: NURSES WHO ARE ALSO TRADITIONAL HEALERS ........................................... 141
  3.2.4.1 Theme 1: Participants experienced role conflict at different levels while working in the clinical area .................................................... 143
  3.2.4.2 Theme 2: Participants perceived that the Act would create opportunities for them .............................................................. 147
  3.2.4.3 Theme 3: Participants advocated for capacity building of traditional and allopathic health practitioners in preparation for facilitating collaboration and cross-referral of patients ........................................ 149

3.2.5 A summary of findings from all groups of participants ........................................ 152

3.3 CHAPTER SUMMARY ............................................................. 154
### CHAPTER 4: DEVELOPMENT OF A CONCEPTUAL FRAMEWORK OF STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
<td>155</td>
</tr>
<tr>
<td>4.2</td>
<td>THE CURRENT SCENARIO</td>
<td>156</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Policy changes</td>
<td>156</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Progress made by the national department of health on traditional healing</td>
<td>158</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Progress in the Provincial Department of Health</td>
<td>159</td>
</tr>
<tr>
<td>4.3</td>
<td>THE CONCEPT OF KNOWING</td>
<td>162</td>
</tr>
<tr>
<td>4.4</td>
<td>COGITATION MAP</td>
<td>169</td>
</tr>
<tr>
<td>4.4.1</td>
<td>Framework</td>
<td>171</td>
</tr>
<tr>
<td>4.4.2</td>
<td>The agent</td>
<td>172</td>
</tr>
<tr>
<td>4.4.3</td>
<td>Recipiency</td>
<td>174</td>
</tr>
<tr>
<td>4.4.4</td>
<td>Terminus</td>
<td>175</td>
</tr>
<tr>
<td>4.4.5</td>
<td>Procedure</td>
<td>176</td>
</tr>
<tr>
<td>4.4.6</td>
<td>Dynamics</td>
<td>178</td>
</tr>
<tr>
<td>4.5</td>
<td>CHAPTER SUMMARY</td>
<td>181</td>
</tr>
</tbody>
</table>

### CHAPTER 5: DESCRIPTION OF THE STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>INTRODUCTION</td>
<td>182</td>
</tr>
<tr>
<td>5.2</td>
<td>STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS</td>
<td>183</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Strategy to change the negative attitude of allopathic and traditional health practitioners</td>
<td>186</td>
</tr>
<tr>
<td>5.2.2</td>
<td>The communication strategy</td>
<td>200</td>
</tr>
<tr>
<td>5.2.3</td>
<td>The capacity building strategy</td>
<td>213</td>
</tr>
</tbody>
</table>
5.3 THE ROLE OF THE AGENT RESPONSIBLE FOR IMPLEMENTATION OF THE STRATEGIES ........................................................................................................ 226
5.4 CHAPTER SUMMARY ................................................................................ 232

CHAPTER 6: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS .................. 233

6.1 INTRODUCTION .......................................................................................... 233
6.2 CONCLUSIONS ........................................................................................... 233

6.2.1 Objective 1: To explore and describe the nature of the relationship between allopathic and traditional health practitioners before legalisation of traditional healing and their experience as role-players in the healthcare delivery landscape in the Amathole District Municipality ........................................................................................................... 236

6.2.2 Objective 2: To elicit the viewpoints of traditional and allopathic health practitioners regarding the impact on their practices of legalisation of traditional healing ........................................................................................................... 237

6.2.3 Objective 3: To develop strategies to facilitate collaboration between allopathic and traditional health practitioners to optimise and complement healthcare delivery ........................................................................................................... 238

6.3 LIMITATIONS OF THE STUDY ...................................................................... 240
6.4 RECOMMENDATIONS ................................................................................... 243

6.4.1 Implications for policy making .............................................................. 244
6.4.2 Implications for medical, pharmacy and nursing education ................. 246
6.4.3 Implications for nursing and medical practice ........................................ 247
6.4.4 Implications for further research .......................................................... 249

6.5 CONCLUDING REMARKS .......................................................................... 249

BIBLIOGRAPHY ................................................................................................. 251
ANNEXURES

ANNEXURE A: CORRESPONDENCE PERTAINING TO THE GRANTING OF PERMISSION TO CONDUCT RESEARCH .................................. 269
ANNEXURE B: LETTER AND FORM TO THE ALLOPATHIC HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY .................................................................................... 272
ANNEXURE C: LETTER AND FORM TO THE TRADITIONAL HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY .................................................................................... 276
ANNEXURE D: INFORMED CONSENT ......................................................................................................................... 282
ANNEXURE E: LETTER TO THE NURSES WHO ARE TRADITIONAL HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY .................................................................................... 285
ANNEXURE F: PROTOCOL FOR THE INDEPENDENT CODER ......................................................................................... 289
ANNEXURE G: TRANSCRIPTION OF AUDIO-TAPED FOCUS GROUP AND INDIVIDUAL INTERVIEWS ................................................................................................................................. 292
ANNEXURE H: MAPS
MAP 1: EASTERN CAPE HEALTH DISTRICTS .............................................................................................................................. 376
AND SUB-DISTRICTS/LOCAL SERVICE AREAS
MAP 11: AMATHOLE DISTRICT MUNICIPALITY ..................................................................................................................... 376
LIST OF TABLES

Table 2.1 Criteria to ensure trustworthiness.................................................................74
Table 3.1: Profile of Group 1 participants forming the focus group interview:
   Allopathic health practitioners .............................................................................82
Table 3.2: Themes and sub-themes from Group 1 participants: Allopathic
   health practitioners.............................................................................................83
Table 3.3: Profile of Group 1a participants...............................................................107
Table 3.4: Profile of Group 2 participants: Traditional health practitioners........109
Table 3.5: The identified themes and sub-themes relating to Group 2:
   Traditional health practitioners ........................................................................111
Table 3.6: Profile of nurses who were also traditional health practitioners........141
Table 3.7: Identified themes and sub-themes relating to Group 3: Nurses
   who were traditional health practitioners .........................................................142

LIST OF FIGURES

Figure 4.1: Extract from the organizational structure of the Eastern Cape
   Department of Health-June 2007 .......................................................................160
Figure 4.2: Cogitation map......................................................................................170
Figure 4.3: Cogitation map on conceptual framework to facilitate
   Collaboration........................................................................................................179
Figure 5.1: Summary of the strategies developed to facilitate collaboration
   between allopathic and traditional health practitioners.......................................223
CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Every society has a varied set of strategies and traditions that are relied upon to maintain and restore well-being. These features are embedded in the health and medical systems of every human community (Gesler in Arthur, 1997:63). In some communities a number of medical systems or ways of perceiving, explaining and treating illness and disease exist. These systems are the lay referral system, the alternative medical system, traditional healing and the allopathic or professional medical systems. The existence of the different medical systems can be attributed to the differences between cultures and their understanding of health and disease. This co-existence and availability of different medical systems is termed “medical pluralism” (Gilbert, Selikow & Walker, 1996: 49; Janzel in Sindinga, Nyaigotti-Chacha, Kanunah, 1995:23).

Members of most communities generally display a similar help-seeking behaviour pattern once they realise that their health is being threatened. The first step that a sick person usually takes is self-medication, using a variety of substances such as patent medicines, traditional folk remedies and diet. This will be followed by consultation with family members, friends and neighbours whose credentials tend mainly to be their own experience of the disease rather than their educational or social status. This is referred to as the lay referral system (Freidson in Gilbert et al., 1996:49 & 61). If there is no improvement, the sick person may consult a healer from any health sector. According to Gilbert, Selikow and Walker (1996:50), the health sector generally falls into two categories. The first category is the orthodox, allopathic, professional, modern or western sector and the
second is referred to as the folk, alternative, complementary or traditional health sector (Gilbert et al., 1996: 50).

The allopathic, professional or modern medical system which is dominant in most western countries, includes physicians of all specialities with recognised allied medical disciplines, for example, nurses, physiotherapists and radiotherapists. It is characterised by the application of scientific medical knowledge and technology to health and the healing process (Gilbert et al., 1996:50). Allopathic or modern medicine which regards the body in purely mechanistic terms includes notions that life processes can be controlled by mechanized and engineered interventions (Hammond–Tooke in Arthur, 1997:63). The biomedical model used by allopathic or orthodox healers accepts the doctrine of specific aetiology, postulating that specific diseases are caused by specific organisms (germ theory) and conditions. The disease is thus regarded as being caused by natural or unnatural factors and treatment is geared towards controlling or removing the cause in a rational and specific manner (Cockerham in Arthur, 1997:63). The connection between health and disease is mechanistic and scientific and governed by physical, chemical and biological laws which embrace concepts such as viruses, cell division and chemical imbalances (Arthur, 1997:63). The testing, measurement and scientific observation of disease and drugs is one of the key issues which distinguishes allopathic medicine from other medical systems (Gilbert et al., 1996:50). In most countries the practitioners of scientific medicine form the only group of healers who are recognised and upheld by law. They often enjoy high status and have more clearly defined rights than other healers. The main institutional structure of scientific medicine is the hospital. Within that framework the sick person is removed from the family or community and placed in a curative setting (Gilbert et al., 1996:50). Allopathic medicine is thus firmly located within a scientific paradigm.

The traditional medical system as a second health sector has survived in Africa despite the successful introduction of modern medicine. Pretorius (1991:10) provides an explanation for its survival by arguing that following independence of
some African states in the sixties, Africans felt the need to rediscover their socio-cultural identity and traditional medicine, being an integral part of their cultural heritage, benefited from that move. In addition, economic circumstances after independence in most African countries were such that imported medicines became less accessible to Africans than before. Authorities were then forced to resort to using indigenous sources (Pretorius, 1991:10). This made the use of alternative medicine popular and resulted in increased visibility of traditional healers.

Traditional medicine entails the sum total of all knowledge and practices (whether they can be explained or not), used in the diagnosis, prevention and elimination of physical, social or mental imbalances and relying exclusively on observation and practical experience handed down from generation to generation verbally or in writing (World Health Organisation, 2001b:3). Traditional healing is based upon a religious frame of reference (Dovey & Mjingwana in Arthur, 1997:63). Ideas of health and illness are an integral part of a religious system in which belief in life after death plays an important role. According to traditional African cosmology, the universe comprises two worlds; the world in which man lives and the world of the ancestral spirits. As spiritual beings, the ancestral spirits are invisible members of society who care for and carry responsibility for actions of their descendants. Health, prosperity and misfortune or ill-health are attributed to the continued goodwill or wrath of the ancestors by traditional communities (Mdleleni in Arthur, 1997:63). When a disease does not respond to western types of treatments, the cause is believed to be witchcraft, sorcery and ancestral powers; therefore it is considered best to consult a traditional healer who may be able to cure the condition (Uys, 1992:84).

The traditional healer is a person recognised by the community as being competent to provide healthcare through the use of vegetable, animal and mineral substances as well as the use of certain methods based on the social, religious and cultural background of the community (Ampofo & Johnson-Romauld
in Sindiga et al., 1995:17). Traditional healers often share the same socio-cultural values as their communities, including beliefs about the origins, significance and treatment of ill-health. They adopt the psycho-social model in their practice which means that their approach is holistic, taking into consideration the physical, psychological, spiritual and social aspects when attending to the health needs of individuals, families and communities (Abdool Karim, Ziqubu-Page & Arendse, 1994:3). In most cases the traditional healer’s home acts as his hospital but some clients are treated in their own homes. Whereas western biomedicine approaches ill-health from the perspective of what caused it and how, traditional healing also deals with who caused it and why (Abdool Karim et al., 1994:6). There is however, some confusion regarding who the traditional healers are. Several authors (Troskie, 1997a:15 &16; Abdool Karim et al., 1994:7-8 & Setswe, 1999:57) classify traditional healers into four categories:- traditional doctors, diviners, faith healers and traditional birth attendants.

- **The traditional doctor (Ixhwele)**
  Traditional doctors are predominantly men who specialise in the use of herbal medicines. They acquire this skill by being apprenticed to experienced practising traditional doctors. At the end of the training period, an agreed upon amount, be it a beast or money, is paid to the tutor. Sometimes the traditional doctor passes on his skill to one or more of his sons who show an interest in the practice. The field of a traditional doctor includes preventive and curative treatment; and preparations for luck and fidelity (Gilbert et al., 1996:75).

- **The diviner (Igqira)**
  Diviners are usually women who qualify after undergoing the "ukuthwasa" process. "Ukuthwasa" is a process which an individual has to undergo in acquiring the knowledge and skills of traditional healing (Mqotsi, 1957:188). Culturally, this is regarded as an acceptable form of ancestral spirit possession, when the “chosen one” is called by the ancestors to become a diviner. The Xhosas regard “ukuthwasa” as a form of illness with an underlying idea of spirit
possession. They say that the person who is undergoing the “thwasa” process has a spirit (umshologu) or a demon (indimoni) (Mqotsi, 1957:188). It is this possessing spirit that is responsible for the appearance of the first symptoms of “ukuthwasa”. The calling manifests itself in a variety of behavioural disturbances or by symptoms of mental or physical illness (Felhaber, 1999:22). A person may for instance be fond of staying alone, singing sad songs and occasionally crying for no apparent reason. She/he becomes irritated when somebody whistles, and develops a fear for shining objects like mirrors. She/he complains of palpitations, hiccups and bad dreams, wanders around and becomes reluctant to eat or put on clothes (Mqotsi, 1957:243). The diagnosis that the person is engaging in the “thwasa” process will be made by a qualified diviner. As soon as this person who is now called “ithwasa” has undergone initiation as a traditional healer, she/he is brought into contact with the larger community of the ancestral spirits and enjoys the guidance of the abundant wisdom of the illustrious dead (Mqotsi, 1957:188).

The second way in which a person can go through the “thwasa” process is through the “forest” (Mqotsi, 1957:243). In this case she/he spends some time alone in the forest, clad in leaves and animal hides and becomes associated with a particular wild animal (isilo)-be it a leopard, lion or elephant. The nature of this association is not openly explained; but she/he reacts in an aggressive manner when somebody mentions this animal. The diagnosis and initiation is done by a qualified diviner in the same manner as has been mentioned above.

Some people “thwasa” at the river. A person is believed to have disappeared into a river and is said to be called by the river people where she/he will be taught the use of various kinds of traditional medicines. She/he will come out decorated with white clay and beads after her/his family has slaughtered a dun-coloured beast and brought it to the riverside where she/he had disappeared. This ritual is performed on the instruction and guidance of a fully-fledged diviner who is well known for rectitude, honesty as well as professional efficiency. If all rites are properly performed the “ithwasa” becomes an accomplished diviner. It is generally believed that river doctors are the best as they have come into contact
with the hidden wisdom of the world under the water (Mqotsi, 1957:244). It is thus not a person’s choice to become a diviner but that of her/his ancestors who bestow clairvoyant power upon her/him. The called neophyte learns about herbs from a qualified diviner while ancestors reveal some knowledge to her/him through dreams. The duration and venue of training differ with each individual. The diviner acts as a diagnostician and is consulted to find out why a certain calamity has come about (Gumede, 1990:69). During such consultation sessions the diviner may or may not throw bones to make the diagnosis (Felhaber, 1999:28). When thrown down the bones form a pattern and the ancestral spirits tell the diviner what is wrong with the patient. It is not the patient who reveals the symptoms or nature of the disease (Troskie, 1997b:34). The diviner’s speciality is therefore divination within a supernatural context through culturally accepted “mediumship” with the ancestral spirits (Abdool Karim et al., 1994:7).

- The faith healer
Faith healers are people who use the power of suggestion, prayer and faith in God to promote healing. They appeal to God to change a person’s physical or mental condition for the better (Cockerham, 1992:124). They believe that their healing power comes from God through ecstatic states and trance-contact with a Christian holy spirit and/or ancestral spirit (Setswe, 1999:57). Their healing methods entail prayer and laying on of hands or provision of holy water, ash or salt. They divine and heal within a group in the context of a church or religious ceremony and within the framework of the African Independent Churches. These churches integrate both worshipping and healing within the indigenous belief system (Farrand, 1984:779). There is, however, no consensus on the inclusion of this category. The controversy regarding their recognition as traditional healers is around their training (Jones, 1998:1057).

- The traditional birth attendant /Traditional midwife
The traditional birth attendant is a middle-aged or elderly lady with no formal training who attends to women during pregnancy, labour and post natal period by
using herbs to facilitate delivery or cause bleeding of the uterus post-natally (Nolte, 1998:59). Traditional birth attendants do not charge for their services but donations in kind or gifts are usually given. Women aspiring to be traditional birth attendants are required to satisfy certain criteria, for example, they should have had at least two babies in order to be able to appreciate the joys and agonies of childbirth. Their training entails 15-20 years of apprenticeship before they assume the title (Abdool Karim et al., 1994:8). Some authors like Troskie (1997a:16) prefer to use the term “traditional midwife” arguing that this category of healer does more than just deliver a baby: she looks after clients from the beginning of pregnancy until after the baby is born.

The present Traditional Health Practitioners Act, Act No 22 of 2007, classifies traditional healers into four groups:- diviners, herbalists, traditional birth attendants and traditional surgeons. The Act, does not, however, make reference to faith healers. Although each type of traditional healer has distinctive features, the different types tend to overlap and there are grades within each type from novice to specialist.

Stepan (in Pretorius, 1991:10) presents a macro and micro perspective on traditional medicine. He maintains that on a macro perspective, the legislative approaches to traditional medicine fall into four broad categories:- exclusive systems, tolerant systems, inclusive systems and integrated systems. In the exclusive systems, only the practice of modern medicine system is regarded as legal, while all other forms of healing systems are excluded. The tolerant system only recognises the system based on allopathic medicine while the existence and significance of the traditional sector is ignored. In the inclusive or parallel systems, traditions other than the allopathic medicine are recognised legally so that two or more systems of health co-exist. In order to be eligible for such organisational inclusion, the particular traditional system has to be highly formalised. This implies that such a medical system must possess medical traditions, literature and teaching systems which can be studied and continued. In integrated systems modern and traditional medicine are united in terms of
medical training and jointly practised in a unique healthcare system. The integrated training of practitioners which is now official policy is a feature in countries like China (Zhixiang, 2006:1), Republic of Korea and Vietnam (World Health Organization, 2002:9).

A micro perspective on traditional medicine focuses on usage patterns. Stepan (in Pretorius, 1991:11) points out that while policy-makers and the World Health Organization have just begun contemplating the co-ordination and integration of traditional and modern medicine, the public have been using both for a very long time. Usage patterns are established by persons moving from one sector of a healthcare system to another in search of diagnosis, healing or other services. A pattern is simultaneous when a patient consults different sectors concurrently. Usage patterns are interchangeable in that certain illnesses are taken for treatment to one sector while the other sector is used in the case of other conditions. The phenomenon of dual usage of medical resources is significant especially in the present study because it provides a basis for attempts at collaboration between modern and traditional healing (Pretorius, 1991:11).

In Africa there is a growing trend towards either inclusive (parallel) or integrated systems (Pretorius, 1991:11). With a view to conceptualising the conditions for liaison between the two systems, the analogical model of the Biomedical/Traditional Medical Relationship proposed by Pretorius (1999:11) can be used. From this model it becomes clear that each aspect of the traditional medical system may be linked to the modern medical system and vice versa. The counterpart of herbalism for instance is to be found in pharmaceutical services, while traditional midwifery corresponds to the area of maternal and child health. The surgical aspects of modern medicine correlate with ritual manipulations such as blood-letting while traditional taboos which aim at appropriating health behaviour and prohibiting actions which may threaten health correspond to preventive health measures in the modern medical system. Pretorius (1991:11) advises that in order to create a new type of national healthcare delivery system,
traditional medicine can be made relevant through either complementarity/co-operation (inclusive parallel system) or through integration. When the relationship of complementarity/co-operation exists, traditional and modern medicine co-exist as two independent sectors each respecting the uniqueness of the other. Co-operation is a step forward to complementarity in that it is a multi-faceted process including aspects such as mutual referral (Yoder in Pretorius, 1991:11), professionalisation of traditional medicine (Staugard in Pretorius, 1991:11) and intercalation. Intercalation is the adoption of *materia medica* from the traditional medical sector not because these remedies are more beneficial than similar drugs already existing in the pharmacopoeia of modern medicine, but because they correspond to these drugs (Yoder in Pretorius, 1991:11). Intercalation of drugs could have an economic advantage in that fewer drugs will have to be imported. It appears that for any linking programme to be successful, four stakeholders have to co-operate, namely, the authorities responsible for healthcare delivery, the healthcare workers trained in western medicine, the traditional healers and the consumers of these services (Pretorius, 1991:12).

The formal recognition of traditional healing and its integration or incorporation into existing healthcare services has been controversial for some time. Many arguments have been offered for and against their incorporation. Thairu (in Sindiga et al., 1995:17) argues that part of the misunderstanding regarding African traditional healers emanates from a historical perspective. Historically, African traditional healers were dubbed “witches” practicing black magic. Missionaries were particularly negative towards traditional healers, viewing them as an impediment to repentance (Mulaudzi, 2001:15). Nevertheless, some initiatives have already been undertaken to bring the two systems together in a number of the African states.

In Zimbabwe, for example, the Government formally recognised the role of traditional healers immediately after independence in 1975; and a policy of integrating western and traditional medicine was established. It has been stated
though, that co-operation between the two is still limited although characterised by mutual respect and understanding (Gilbert et al., 1996:72). Referrals do occur, but they are mostly from the traditional healers to the modern health sector and seldom in the other direction. The idea that traditional health practitioners must pass a litmus test in which they are scientifically scrutinised before they can be integrated into the national health services still exists. In Mozambique, the first independent government banned traditional healing, maintaining that it promoted superstition and exploited the poor. In spite of that, people continued to use traditional healers. The authorities then used a more pragmatic approach by allowing the people to choose the healthcare system they preferred while marketing the effectiveness of modern medicine (Gilbert et al., 1996:72). While there is no formal recognition of traditional healers in Swaziland, the Government has encouraged links and participated in joint healthcare programmes with traditional healers. In Kenya, 80% of births are conducted at home by the traditional birth attendants rather than by midwives in a maternity hospital ward. In spite of the prominent role that traditional medicine plays in healthcare in Kenya, Sindiga et al. (1995:7) maintain that it is the least understood of all medical systems. Both modern and traditional medical systems have co-existed as parallel systems with little co-ordination between them.

In South Africa, before legalisation of traditional medicine in 2004, there was an estimated figure of between 150,000 and 200,000 traditional healers with the healer population ratio of 1:200. They were organised and "licensed" by approximately 100 organisations that were officially registered under the Companies Act and not as health providers. These healers were treated with disdain and apathy by those of conventional medical orientation. They were labelled witchdoctors, purveyors of superstition, and a medical hazard practicing "pseudo-psychological mumbo jumbo" (Gilbert et al., 1996:73). This labelling of traditional healers is however, gradually changing especially in the Province of the Eastern Cape. Global trends regarding traditional healing may probably have influenced this attitudinal change. The World Health Organization, for instance,
has estimated that 80% of the population living in the rural areas of many developing countries use traditional medicine for their primary healthcare needs (World Health Organization, 2001a:1). As a result the World Health Organization advocated for the integration into health systems of traditional medical practices and traditional medicines which have been tested for safety, efficacy and quality. Integration in this context refers to increase of healthcare coverage through collaboration, communication and partnership-building between allopathic and traditional systems of medicine, while ensuring property rights as well as protection of indigenous knowledge (World Health Organization, 2001b:3).

Over the past years the World Health Organization governing bodies, namely, the World Health Assembly, the World Health Executive Board and the World Health Regional Committee for Africa have passed a number of resolutions or recommendations in response to the growing interest in the study and use of traditional medicine and in recognition of the importance of the use of medicinal plants in health systems of many developing countries (World Health Organisation, 2001b:1). One of the recommendations made at a meeting of the African Forum on the Role of Traditional Medicine in Health Systems, was to establish mechanisms that would facilitate strong co-operation between traditional healers, scientists and clinicians with acceptable arrangements for improved and loyal collaboration (World Health Organisation, 2001a:31). The World Health Organisation urged member states, of which South Africa is one, to prepare specific legislation to govern the practice of traditional medicine as part of the national health legislation (World Health Organisation, 2001a:30). The promulgation of the Traditional Health Practitioners Act, Act 35 of 2004 (recently amended as Act 22 of 2007) by the South African government is the culmination thereof. Details pertaining to this legislation will be discussed in chapter 4.
1.2 PROBLEM STATEMENT

The health and welfare of any nation is primarily the responsibility of its government. This is also the case in South Africa where the provision of preventive, promotive, curative and rehabilitative health services is the responsibility of the state. Chapter 1 Section 3 (1) (c) of the National Health Act, Act No. 61 of 2003, assigns this responsibility to the Minister of Health who has to determine policies and measures necessary to protect, promote, improve and maintain the well-being of the population. In order to provide the required protection of users of traditional health services, the South African government promulgated the Traditional Health Practitioners Act, Act No. 35 of 2004 amended as Act No. 22 of 2007.

Section 5 of the Traditional Health Practitioners Act provides for the establishment of an Interim Traditional Health Practitioners Council of the Republic of South Africa. One of the functions of this Council as outlined in Chapter 2 Section 6 (2) (a), is to promote and regulate liaison between traditional health practitioners and other health professionals registered under any law. Currently, in the Province of the Eastern Cape particularly in the Amathole District Municipality, the only regulated working relationship or liaison is between allopathic health practitioners and traditional surgeons and is regulated through the Application of Health Standards in Traditional Circumcision Act, Act No. 66 of 2001. To the knowledge of the researcher, there is no other formally structured or documented strategy to facilitate liaison/collaboration between traditional and allopathic health practitioners in the Amathole District Municipality as proposed in the Traditional Health Practitioners Act. There is thus no clear information as to how the allopathic health practitioners were liaising or collaborating with the traditional health practitioners prior to the legalization of traditional medicine and how each other’s practices have been influencing or affecting the other. As both types of practitioners were working within the same communities, the practice of each type of healer may have had a synergistic or detrimental effect on the
other’s practice to the benefit or disadvantage of the consumers of health services.

It thus becomes necessary to explore and describe the nature of the relationship that has existed between allopathic and traditional health practitioners as experienced by them as role players in the healthcare delivery landscape in the Amathole District Municipality, Province of the Eastern Cape and to establish further, the viewpoints of allopathic and traditional health practitioners regarding the impact that the new legislation on traditional health practitioners will have on the practice of both allopathic and traditional health practitioners. On the basis of that information, strategies will be developed to facilitate collaboration between allopathic and traditional health practitioners thereby optimising and complementing healthcare delivery.

1.3 RESEARCH QUESTIONS

The following research questions were posed to give direction to the study:

- What was the relationship between allopathic and traditional health practitioners in the Amathole District Municipality in the Province of the Eastern Cape prior to the legalisation of traditional healing and what has been the experience of these health practitioners as role players in the healthcare delivery landscape in this municipality?
- What are the viewpoints of allopathic and traditional health practitioners regarding the impact that legalisation of traditional health practitioners will have on their respective practices and ultimately on healthcare delivery?
- How should collaboration between allopathic and traditional health practitioners be facilitated to optimise and complement healthcare delivery?
1.4 PURPOSE AND OBJECTIVES OF THE STUDY

The study was conducted to achieve the following purpose and objectives:

1.4.1 PURPOSE OF THE STUDY

The purpose of the study was to develop and propose strategies to facilitate collaboration between traditional and allopathic health practitioners to optimise and complement healthcare delivery.

1.4.2 OBJECTIVES

The specific objectives of this study are:

- To explore and describe the nature of the relationship between allopathic and traditional health practitioners prior to legalisation of traditional healing as well as their experience as role players in the healthcare delivery landscape in the Amathole District Municipality.
- To elicit the viewpoints of traditional and allopathic health practitioners regarding the impact of legalisation of traditional healing on their respective practices.
- To develop strategies to facilitate collaboration between traditional and allopathic health practitioners to optimise and complement healthcare delivery.

1.5 RELEVANCE OF THE STUDY

The study is very relevant when viewed against the backdrop of both national and international imperatives. From an international perspective, it is in line with a decision that was endorsed at the summit of the Assembly of the Organisation for African Union held in Lusaka in 2001, which declared the period between 2001-2010 as a Decade for African Traditional Medicine (Diallo, 2005:2). A Plan of Action was drawn up to elaborate this notion for member states and it called for recognition, acceptance, development and integration of traditional medicine by all member states into the public healthcare system in the region by 2010. As
South Africa is a member of the Organisation for African Union, it is bound by the decisions and recommendations of this body.

One of the recommendations made at a meeting of the African Forum on the Role of Traditional Medicine in Health Systems, was the establishment of mechanisms that would facilitate strong co-operation between traditional healers, scientists and clinicians with acceptable arrangements for improved and loyal collaboration (World Health Organisation, 2001a:31). The present study will invariably address the aforementioned aspects as it aims at developing strategies to facilitate collaboration between allopathic and traditional health practitioners. Furthermore, in Maputo in 2003, the African Summit of Heads of State and Government, declared that traditional medicine research be a priority. Conducting research on this topic is thus in line with the proposed focus area.

The study is also relevant when viewed against the stance taken by the South African Ministry of Health regarding institutionalisation and operationalisation of traditional medicine. The previous Minister of Health in South Africa, Doctor Tshabalala-Msimang had continuously emphasised her viewpoint regarding the potential of traditional health practitioners to serve as a critical component of a comprehensive health care strategy. She viewed traditional medicine as playing a significant role in the management and treatment of the most devastating and life-threatening diseases such as HIV and AIDS, tuberculosis, malaria, diabetes mellitus and cancer (Tshabalala-Msimang, 2006:1). Her viewpoint was also echoed at a conference on traditional medicine held in Benoni in June 2006, by the Director-General for Health, Mr Mseleku, who highlighted the need to find a rightful place for traditional medicine, but conceded that there was paucity of knowledge and understanding of traditional medicine as this has been a marginalised discipline. Conducting research aimed at establishing collaborative linkages between allopathic and traditional health practitioners is therefore, relevant within the current landscape of South Africa’s health system.
The value of this study is evident as it is a response to recommendations made by other researchers (Broom & Tovey, 2007:608; Hopa et al., 1996:94; King, 2000:36; Kgoatla, 1997:31 & Van Wyk, 2005:21) who have called for more research to be conducted on this topic not only into the methods that traditional healers use and the impact of the training projects, but also into the relationship between the traditional and biomedical healthcare systems.

1.6. CONCEPTUAL FRAMEWORK

The conceptual framework guiding this study will be derived from Leininger’s theory of Culture Care Diversity and Universality (Fitzpatrick & Whall, 2005:178). In this theory Leininger provides definitions of human, environment, culture, health, worldview, nursing, cultural care diversity and cultural care universality. The researcher has chosen Leininger’s theory because it emphasises culture and is therefore appropriate for this study as traditional healing is a culturally rooted healthcare practice. It is generally accepted that culture influences all aspects of people’s lives including everyday behaviour like dress code, eating and reaction to health, illness and disease. Health, illness and sick role behaviour can therefore be seen as cultural constructs. Leininger presents assumptions that different cultures perceive, know and practise care in different ways, yet there are commonalities about care among all cultures of the world. She refers to the commonalities as universality and to the differences as diversity (Leininger, 1991:29).

Leininger’s theory of culture care diversity and universality addresses clients as humans who are “cultural beings” having survived through time and place because of their ability to care for infants, young and older adults in a variety of environments and ways (Fitzpatrick & Whall, 2005:180). Viewing humans as cultural beings supports the idea that humans cannot be separated and viewed apart from their cultural background. Humans need to be viewed and understood in their context; and culture is the broadest and more holistic perspective that allows this perspective. This argument supports the notion of wholeness of man.
Many nursing theorists view man as a biopsychosocial being with physical, psychological and social aspects (Chinn & Kramer, 1995:43), the social part encompassing the spiritual and cultural aspects. From Leininger’s perspective human beings include individuals, families and cultural groups, a dimension that gives considerable scope to the theory (Fitzpatrick & Whall, 2005:180). In this study “man” or “human” encompasses providers of healthcare namely medical practitioners, nurses, and pharmacists as well as traditional health practitioners specifically diviners, traditional doctors, traditional surgeons and traditional birth attendants. “Man” will also refer to all community members as recipients of healthcare.

**Environment:** This refers to all the contextual aspects in which individuals and cultural groups live. These aspects include physical, ecological, social and world view features and all other immediate factors that influence their lifestyles. For Leininger, human behaviour is meaningful only within specific environmental and cultural contexts. Environment influences health and care patterns of individuals, families and cultural groups (Fitzpatrick & Whall, 2005:180-181).

**Culture:** This concept is defined by Leininger (1991:47) as learned, shared and transmitted values, beliefs, norms and lifeway practices of a particular group that guide thinking, decisions and actions in patterned ways (Leininger, 1991:47). According to Leininger (1991:25) all human cultures had some forms, patterns, expressions and structures of care to know, explain and predict well-being, health or illness status. Cultural values and beliefs are thus held to be the strongest and most powerful predictors of health and care patterns of individuals, families and communities (Fitzpatrick & Whall, 2005:184).

**Health:** Health is more than absence of disease. It refers to beliefs, values and action patterns that are culturally known and used to preserve and maintain personal or group well-being and to perform daily role activities. The emic approach to health incorporates the idea that health may be perceived differently.
according to one’s cultural background. According to Leininger’s theory health is embedded in the social structure and has to be abstracted from this frame of reference. Social structure refers to major interdependent and dynamic structural and functional elements of religious, kinship, political, economical, educational, technological and cultural values of a particular group screened through linguistic and environmental contexts. A social structure frame of reference provides a holistic view of people in their physical and socio-cultural environments (Fitzpatrick & Whall, 2005:181).

The goal of health is preservation and maintenance of well-being for individuals, families, groups and specifically cultures. A person can seldom claim health in the absence of the ability to perform daily role activities according to cultural expectations (Leininger, 1991:48). According to Leininger (in Fitzpatrick & Whall, 2005:182), health tends to vary from culture to culture because of differences in values, social structure, and worldview dimensions. Worldview is one’s philosophical frame of reference in looking at one’s world (Andrews & Boyle, 1995:356 & Leininger, 1991:47). It reflects the total configuration of beliefs and practices and permeates every aspect of life within the culture of that group (Andrews & Boyle, 1995:8). The worldview that one adheres to, determines the way one perceives, thinks, feels and experiences the world. The nature, meaning and structure of health must therefore be discovered from the point of view of the client’s cultural background.

Nursing: as defined by Leininger (1991:47) is a learnt humanistic and scientific profession and discipline which is focused on human care phenomena and activities in order to assist, support, facilitate or enable individuals and groups to maintain or regain their well-being or health in culturally meaningful and beneficial ways (Leininger, 1991:47). For Leininger human care is the critical and essential element of nursing. It is the essence of nursing (Fitzpatrick & Whall, 2005:179). Leininger distinguishes between the concept of professional nursing care and generic or folk care. Professional nursing care refers to the formal and
cognitively learnt professional care knowledge and practice skills obtained through educational institutions that are used to provide assistive, supportive, enabling or facilitative acts to another individual or group in order to improve a human health condition, disability or lifestyle as well as to work with dying clients (Fitzpatrick & Whall, 2005:182). Generic care refers to culturally learnt and transmitted lay, indigenous (traditional) or folk knowledge and skills used to provide assistive, supportive, enabling acts for another individual or group with evident or anticipated needs to ameliorate the human health condition, disability, lifestyle or help people face death (Fitzpatrick & Whall, 2005:182). This distinction is very significant in the present study as the objective of the study is to elicit the viewpoints of allopathic and traditional healers regarding mechanisms that can be instituted to develop strategies to facilitate collaboration between allopathic and traditional healthcare systems through which professional and generic nursing care respectively, is provided. The strategies for facilitating collaboration aim at complementing and optimising health service delivery.

**Cultural Care Universality** refers to those attributes found to be generally common or potentially universal about care and health, whereas **Cultural Care Diversity** refers to the variabilities and or differences in care meanings and patterns (Fitzpatrick & Whall, 2005: 180). Leininger’s theory of transcultural care diversity and universality provides a unique conceptual, theoretical, and research approach and is appropriate in this study as participants come from different cultures with different world views about health and illness.

### 1.7. CONTEXTUAL CONCEPT CLARIFICATION

The definitions that follow will be used throughout this study.

**Strategy**: A strategy is a broad plan of action with a view to achieving the aim. It outlines the approach one intends to take in order to achieve the purpose (Van der Horst & Mc Donald, 1997:124).
Facilitate: To facilitate is to promote or expedite.

Liaison: Tulloch (1997:878) defines liaison as co-operation or communication especially between units

Collaboration: means co-operation or working jointly (Tulloch, 1997:276). The World Health Organisation (2001a: 3) defines collaboration as a process of working together in a climate where two parties provide mutual assistance and help to attain a common goal. The four characteristics that distinguish collaboration from other types of interactions are that in collaboration the members have shared goals, clearly defined responsibilities, mutual participation and maximisation of resources (Spradley & Allender, 1996:291). The Traditional Health Practitioners Act, Act 22 of 2007 refers to liaison as the required relationship between traditional and allopathic health practitioners, but because the dictionary definitions of both collaboration and liaison link, collaboration and liaison will be used interchangeably in this study.

Allopathic: Allopathic refers to the scientific and empirical medical approach which sees disease as a natural phenomenon subject to investigation by scientific methods (Gilbert et al., 1996:68).

Traditional medicine: Traditional medicine is defined by the World Health Organisation (2001b:3) as the sum total of all knowledge and practices whether explicable or not, used in the diagnosis, prevention and elimination of physical, social or mental imbalance. The traditional medical context relies exclusively on medical experience and observation handed down through the generations, whether verbally or in writing.

Traditional healer: In the African cultural context, a traditional healer is a person recognised by the community as being competent to provide healthcare through
the use of vegetable, animal and mineral substances as well as the use of certain methods based on the social, religious and cultural background of the community (Ampofa & Johnson-Romauld in Sindinga et al., 1995:21). The practices are integrated with the prevalent knowledge, attitudes and beliefs concerning physical, social and mental well-being and the causation of disease and disability. The concept traditional healer was used prior to recognition of traditional healers through legislation.

**Traditional health practitioner:** This concept refers to a person registered or required to be registered in terms of the Traditional Health Practitioners Act, Act No. 22 of 2007 as a traditional birth attendant, traditional surgeon, diviner and herbalist. In this study the term “traditional healer” and “traditional health practitioner” will be used interchangeably.

**Allopathic health practitioner:** A practitioner is someone involved in a usually skilled job or activity. Allopathic health practitioners are those trained in scientific medicine whose positions are upheld by law and include doctors, nurses and para-medical professionals like radiographers and physiotherapists (Gilbert et al., 1996:63).

**Primary Health Care:** This concept refers to essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing healthcare as close as possible to where people live and work (Dennill, King, Lock & Swanepoel, 1995:2).
Ancestors: Ancestors are benevolent spirits who preserve the honour and tradition of a tribe, and protect their people against evil and destructive forces. Ancestors can punish their people by sending illness or misfortune if certain norms are violated or if culturally prescribed rites and practices are neglected or incorrectly performed (Van Dyk, 2001:5).

1.8. RESEARCH DESIGN AND METHODS

This chapter will briefly outline the research design and methodology that was used in the execution of the study. A detailed description of the research design will be done in Chapter 2.

1.8.1. Research Design

A research design is a strategic framework for action that serves as a bridge between research questions and the execution of the research (Terreblanche, Durrheim & Painter, 2006:34). A qualitative, exploratory, descriptive, and contextual research design was used. These terms will be briefly explained to facilitate understanding of the design.

Qualitative research is a way of finding out what people do, know, think or feel by observing and interviewing them as well as analysing documents (Patton, 2002:145). The chief characteristic of qualitative research is a commitment to viewing the social world, that is, the social action and events from the viewpoints of people being studied (Blaike, 2000:251). This commitment involves discovering their socially constructed reality and penetrating their frames of meaning in which they conduct their activities. In order to do this Blaike (2000:251) advises that it is necessary to discover their mutual knowledge, concepts and meanings associated with these concepts. The investigation of this reality and the language in which it is embedded require extended periods of involvement in the lives of
the people by means of participant observation and/or through in-depth interviewing. A qualitative design has been chosen in this study because the data that the researcher wanted to capture and communicate would tell a story of the experiences and viewpoints of allopathic and traditional health practitioners expressed in their own words.

**Exploratory research** is undertaken when very little is known about the topic being investigated or about the context in which the research is to be conducted. The topic may have never been investigated or never in that particular context (Blaike, 2000:73). An exploratory study aims at uncovering the relationships and dimensions of a phenomenon (Talbot, 1994:90). In this study the need to explore arises from a lack of documented information regarding the working relationships between allopathic and traditional health practitioners as role-players in the healthcare delivery system in the Amathole District Municipality.

**In descriptive research**, the goal is to describe that which exists as accurately as possible (Terreblanche, Durrheim & Painter, 2006:44). A characteristic of qualitative research is the importance that is given to producing detailed or “thick” description of the social settings being investigated (Blaike, 2000:251). Qualitative data describes, that is, it takes the readers into the time and place of the observation so that the readers know what it was like to have been there (Patton, 2002:47). In this study the researcher will describe the working relationships between allopathic and traditional health practitioners prior to legalisation of traditional healers and the proposed strategies to facilitate collaboration between allopathic and traditional health practitioners.

**A contextual design** is one involving the studying of the phenomenon of interest in terms of its natural social world (Huberman & Miles, 2002:359-360). “Context” means the physical, geographical, cultural, historical or aesthetic setting within which action takes place (Lawrence-Lightfoot in Patton, 2002:63). Context becomes the reference point and is used to place people and action in time and
space and as a resource for understanding what they say and do. The context is rich in clues for interpreting the experience of the actors in the setting. Lawrence-Lightfoot (in Patton, 2002:63) further points to the difficulty of deciphering a conversation or action unless it is seen embedded in context. According to Schwandt (2001:37), contextualism refers to a humanistic theory which holds that human nature is only specified and made intelligible by the particular context in which it is found. The cultural context is of particular prominence in this study. The context of the study is described in chapter 2.

A brief description of the research population, sampling method and sample size as well as data collection and analysis as applicable to this study follows.

1.8.2 Research Method
This study was conducted in two phases. Phase One involved data gathering in a manner that will be elaborated in Chapter 2. Phase Two entailed development of strategies to facilitate collaboration between traditional and allopathic health practitioners to optimise and complement healthcare delivery. The strategies were based on the findings of Phase One and on information gathered through the literature control, field-notes and modified participant observation.

1.8.2.1 Phase One: Data gathering and analysis
Data collection is the precise, systematic gathering of information relevant to the research purpose or to the specific objectives of a study (Burns & Grove, 2005:43). In this study, data was collected by means of unstructured individual and focus group interviews, modified participant observation, field-notes and literature control.

1.8.2.1.1 Research Population
The research population comprised three groups of health practitioners residing and working in the Amathole District Municipality, Province of the Eastern Cape. Group 1 comprised allopathic health practitioners. Group 2 consisted of traditional healers while Group 3 was composed of participants who were trained
as both traditional healers and allopathic health practitioners. The population, selection criteria, method of sampling, data collection and analysis for each group were as follows:

- **Selection criteria**
The criteria to be adhered to in selecting the participants are described in detail for each group in Chapter 2.

- **Sampling method**
Sampling refers to the process of selecting a portion of the population to represent the entire population (Mason, 2002:125). In this study purposive and snowball sampling were utilised as applicable to each group and are described fully in chapter 2.

- **Sample size**
Sampling was concluded when saturation of data was reached. Saturation is a term used to describe the point at which one has heard the range of ideas and is not getting new information; the point at which one is not gaining new insight (Krueger & Casey, 2000:26). The researcher ensured representation of rural and urban areas, different classifications of health practitioners, gender, racial groups and Local Service Area. The Local Service Areas are Buffalo City, Nkonkobe, Amahlathi, Mbhashe and Mnquma.

**1.8.2.1.2 Data Collection Methods**
Collecting data is about using the selected methods of investigation (Robson, 2002:385). In this study, the data-collection method used for Group 1 participants was a focus group interview while unstructured individual interviews were conducted for Group 2 & Group 3 participants. The interviews were tape-recorded to ensure that the participants’ responses were quoted verbatim or as closely as possible. Modified participant observation, field notes and literature control were also used as data sources.
1.8.2.1.3 Pilot Study
A pilot study was undertaken by conducting an interview with a traditional healer residing in the Amahlathi Local Service Area, and an allopathic health practitioner in Buffalo City and a nurse who is also a traditional healer also from Amahlathi Local Service Area. These participants met all the sample selection criteria and did not participate in the main study. The aim was to determine if the questions generated information that could be used by the researcher and establish if the interview technique was correct (Burns & Grove, 2005:42). The interview was transcribed and analyzed in the planned manner to determine whether themes could be identified.

1.8.2.1.4 Data Analysis
Data analysis is the process of bringing order, structure and interpretations to the mass of collected data (Marshall & Rossman, 1999:150). The tape-recorded data was transcribed verbatim and the transcription utilized as the database for the study. The data was analyzed using Tesch’s method as described by Creswell (2003:192) to identify themes and sub-themes. This method will be discussed comprehensively in Chapter 2. In order to ensure trustworthiness of the study the raw data was sent for analysis to an independent coder who is familiar with qualitative research. The independent coder was given a clean set of the transcripts as well as a guideline of how the data was analyzed. A meeting was arranged with the independent coder for a consensus discussion on the themes and categories reached independently.

1.9 LITERATURE CONTROL
Reviewing the literature provided an academically enriching experience as it was the work and ideas of others that assisted the researcher to understand the history of the subject she intended to study. Once data analysis was completed, a literature control was done to place the findings within the context of what was already known about the topic.
1.10 PHASE 2: DEVELOPING STRATEGIES TO FACILITATE
COLLABORATION

Phase 2 of the study entailed development of strategies to facilitate collaboration between allopathic and traditional health practitioners to complement and optimise healthcare delivery. The strategies were based on the results of Phase 1 and on information gathered through a literature control, fieldnotes and modified participant observation. A conceptual framework was developed and the Survey List by Dickoff et al. (1968:423) was used to provide a scientific basis for the strategies.

1.11 TRUSTWORTHINESS OF THE STUDY

Trustworthiness of the study can be evaluated by determining:–

• how credible the findings of the study are;
• how transferable and applicable these findings are to another setting or group of people;
• how reasonably sure one can be that the findings would be replicated if the study were conducted with the same participants in the same contexts; and
• how sure one can be that the findings are reflective of the subjects and the inquiry itself rather than a creation of the researcher's biases or prejudices of the study (Marshall & Rossman, 1999:143).

In this study trustworthiness was ensured by using Guba’s model of trustworthiness (Krefting, 1991:215). Guba’s model (in Krefting, 1991:214-222) is based on the identification of four criteria of trustworthiness, namely, truth value, applicability, consistency and neutrality. The model defines different strategies of assessing these criteria in each type of research. These strategies assist the researcher in designing means for increasing the rigour of their qualitative studies and also for the readers to use as a means of assessing the value of the findings of qualitative research.
1.12 ETHICAL CONSIDERATIONS

The ethical acceptability of the study was ensured throughout the research process. First and foremost the researcher has an obligation to respect the rights, needs, values and desires of the participants (Creswell, 2003:64). Obtaining written permission to conduct the study, articulating the research objectives verbally and in writing so that they are clearly understood by the participants, including a description of how data would be used and how anonymity and confidentiality of participants would be ensured are some of the measures that were taken to uphold ethical principles. A detailed discussion of ethical considerations will be done in Chapter 2.

1.13 CHAPTER LAYOUT

Chapter 1 - Overview of the study
Chapter 2 - Research design and methods
Chapter 3 - Discussion of findings and literature control
Chapter 4 - Development of a conceptual framework of strategies to facilitate collaboration between allopathic and traditional health practitioners
Chapter 5 - Description of the strategies to facilitate collaboration between allopathic and traditional health practitioners
Chapter 6 - Conclusions, limitations, recommendations and dissemination of results

1.14 CHAPTER SUMMARY

This chapter provides an overview of the study. The purpose and objectives of undertaking the study have been outlined and its relevance highlighted. The problem to be researched has been identified and research questions posed. The population to be studied as well as the means of data collection using unstructured interviews, a focus group interview and modified participant
observation have been stated. Within the scope of the study the impact of
legalising traditional medicine on the practices of traditional and allopathic health
practitioners will be identified. Strategies to facilitate collaboration between
allopathic and traditional health practitioners will be developed to optimise and
complement healthcare delivery. Recommendations will be made and results
disseminated in professional journals, in the annual provincial research
conference and in seminars and conferences.
CHAPTER 2
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

The previous chapter provided an introduction to and overview of the study and described the identified problem and objectives. The researcher’s interest is to establish the nature of the relationship between traditional and allopathic health practitioners prior to the legalization of traditional healing, their experience as role players in the healthcare delivery landscape in the Amathole District Municipality and their perception of the impact that the new legislation on traditional healing will have on the respective practices of allopathic and traditional health practitioners. Based on the data obtained, strategies will be developed to facilitate collaboration between allopathic and traditional health practitioners thereby optimising and complementing healthcare delivery.

2.2 RATIONALE

In undertaking this study, the researcher had the same notion as, and was in full agreement with, the statement made by Hopa, Simbayi and Du Toit (1998:8). These researchers point out that one of the challenges currently facing the health industry in South Africa was the need to develop policy on how to integrate the industry in such a way that it took advantage of the various strands of medicine practised by South Africa’s diverse population. The researcher also concurred with the views of Tomlinson (1991:103) who argues that the time has come in Southern Africa for all those who are interested in the health of the population to refrain from operating in exclusive isolation and agree to work together for the benefit of all. These researchers have further highlighted that this does not mean losing identity or compromising standards, but rather means reaching out to one another for mutual assistance.
It is generally known that allopathic and traditional health systems have co-existed for decades in the Amathole District Municipality in the Province of the Eastern Cape. However, it has never been formally established how the practitioners of the two health systems were relating to one another. Establishing this relationship is crucial as the services of the two health systems were being utilized either concurrently or sequentially by the majority of the black communities residing in this area especially the Xhosa ethnic group. To the best of the researcher’s knowledge, the nature of the relationship between allopathic and traditional health practitioners as role-players in the healthcare delivery landscape in the Amathole District Municipality has not previously been explored. The new legislation on traditional health practitioners stipulates that there should be liaison between the practitioners of the two systems. The proposed strategies may thus assist to facilitate the required liaison/collaboration.

2.3 OBJECTIVES OF THE STUDY

The objectives of undertaking the study are:

- To explore and describe the nature of the relationship between allopathic and traditional health practitioners prior to the legalisation of traditional healing as well as their experience as role players in the healthcare delivery landscape in the Amathole District Municipality;
- to elicit the viewpoints of traditional and allopathic health practitioners regarding the impact of legalisation of traditional healing on their respective practices
- to develop strategies to facilitate collaboration between allopathic and traditional health practitioners to optimise and complement healthcare delivery.

The research design and method used in this study will now be discussed.
2.4 RESEARCH DESIGN AND METHODS

The purpose of this study and the interest in the subject to be researched shaped the research design and methods that the researcher has chosen. A research design which is a blueprint for conducting the study, guides the planning and implementation of the study in a way that is most likely to achieve the intended goal and also maximises control over factors that could interfere with the validity of the findings (Burns & Grove, 2005:211). In developing the research design, Terreblanche, Durrheim & Painter (2006:37) advise that one has to make a series of decisions along four dimensions, namely, the purpose of the research, the theoretical paradigm informing the research, the context or situation within which the research is to be carried out and the research techniques that will be employed to collect and analyse data. In this study a qualitative, exploratory, descriptive, and contextual research design was utilised.

Qualitative research is the study of people’s beliefs, experiences and meaning systems from the perspective of people (Burns & Grove, 2005:747). Qualitative designs are naturalistic to the extent that the research takes place in real world settings and the researcher does not attempt to manipulate the phenomenon of interest. The phenomenon of interest unfolds naturally in that it has no predetermined course established. Observations take place in real-world settings and people are interviewed with open-ended questions in places and under conditions that are comfortable and familiar to them (Patton, 2002:39). The focus is on participants’ perceptions and experiences and the way they make sense of their lives (Creswell, 2003:162). The qualitative researcher uses the induction model of logic, which conceptually means that the researcher develops concepts, insights and understanding from patterns in the data rather than collecting data to assess preconceived models, hypotheses or theories. The most fundamental characteristic of qualitative research is its commitment to viewing events, actions, norms or values from the perspective of the people who are being studied. The strategy of taking the subject’s perspective is often expressed in terms of seeing
through the eyes of the people that are being studied (Bryman, 1995:61). Such an approach involves being prepared to empathise with those being studied but also entails a capacity to penetrate the frames of meaning in which they operate. This opens up a need to comprehend a specialised language (Bryman, 1995:61). Understanding the language is particularly important in the present study as traditional healers use jargon that can be understood better by people of the same ethnic group than by outsiders. The researcher in this case belongs to the same ethnic group as the traditional healers and did not experience any difficulty in understanding the language and connotation of terms used by traditional health practitioners, particularly the diviners. This ability was appropriately displayed by using the expected salutary term “Camagu, Mhlekazi” when greeting the diviner on arrival at his/her home prior to conducting the interviews or when in agreement with a statement he or she made during the interview. The researcher is trained and has practised as an allopathic health practitioner and this too eased understanding of the jargon used by allopathic health practitioners.

A qualitative design was chosen in this study because of its appropriateness. Qualitative data describes and tells a story. It captures and communicates someone else’s experience of the world in his/her own words (Patton, 2002:47). The researcher was interested in obtaining data pertaining to experiences and viewpoints of the participants. Experiences cannot be expressed in numerical or statistical forms but in words and language used by the participants. The purpose of the study was not to make generalisations with the results, but to gain understanding and insight about the experiences of traditional and allopathic health practitioners as stakeholders in the delivery of healthcare in the Amathole District Municipality and their viewpoints regarding the impact that the new legislation on traditional healing would have on their respective practices. The researcher further wanted to determine the mechanisms that were suggested by the traditional and allopathic health practitioners which could contribute to the development of strategies to facilitate collaboration between them. The required information would therefore reflect how these health practitioners thought and felt
and what they believed in. Such human emotions and views are difficult to quantify and the use of quantitative methods in this study would have been irrelevant, hence the choice of a qualitative design.

**Exploratory research** is “discovery” research in which the researcher discovers, frequently with the informant, new meanings and new understanding (Brink & Wood, 1998:312). The need for such a study could arise out of a lack of basic information on a new area of interest (Bless & Higson-Smith, 2006:47). The exploratory researcher looks for new knowledge, new insights, new understanding and new meanings (Brink & Wood, 1998: 312). Whereas data pertaining to the practice of allopathic health practitioners is explicitly documented in the literature, the practice of traditional healers is not; and tends to have areas of misunderstanding. In order to develop strategies to facilitate collaboration between traditional and allopathic health practitioners, there was a need to explore the field of traditional healing as this could help uncover hidden knowledge and skills as well as promote a better understanding of traditional healing. In this study the researcher aimed at discovering new knowledge, insight, meaning and understanding about the nature of the relationship that existed between traditional and allopathic health practitioners prior to the legalisation of traditional healing, the experiences of these health practitioners as stakeholders in the healthcare delivery landscape in the Amathole District Municipality and their viewpoints regarding the impact or implications of the new legislation on traditional healing on their respective practices. The strength of exploratory design according to Brink & Wood (1998:313) is the constant return to informants to verify information. This advantage was taken in the present study. As the researcher had kept the telephone numbers of most of the participants, she was able to contact them and request clarity on certain issues that were mentioned or observed during the interview. As an illustration, the researcher contacted a traditional surgeon who also practised as a diviner, to enquire about the significance of the black academic gown that he had quickly donned on the day of the interview. The response was that the gown was worn to
show respect as this was his practice whenever he had to meet authorities or people who commanded respect. Follow-up of other participants were also made for clarity where there was a void in the information elucidated.

A descriptive design is a way of obtaining accurate information about a phenomenon through observation, description and classification (Brink, 2006:102). In descriptive research, one major feature of well-collected qualitative data is that it focuses on naturally occurring ordinary events with strong potential for revealing complexity (Berg, 2004:11). Traditional healing is a complex and a very controversial issue particularly when it comes to diviners; and the qualitative design provided an accurate portrayal of, critical insight into; and understanding of this healthcare system. The study described the nature of the relationship between allopathic and traditional health practitioners in the Amathole District Municipality prior to the legalisation of traditional healing as narrated by them; the experiences of these health professionals as role players in delivering healthcare to the communities in this municipality and the viewpoints of these health practitioners regarding the impact that legalisation of traditional healing would have on their respective practices and ultimately on healthcare delivery. The study further described in detail the mechanisms that could be instituted to assist the development of strategies to promote collaboration between allopathic and traditional health practitioners in order to complement and optimise healthcare delivery. The experiences and viewpoints of the participants were described as accurately as possible giving the facts from the perspective of the participants and in their own words.

A contextual design is one aiming at describing and understanding events within the concrete, natural context in which they occur (Babbie & Mouton, 2002:272). The implications of contextualism engender a style of research in which the meanings that people ascribe to their own behaviour and that of others have to be set in the context of values, practices and underlying structures of the appropriate entity as well as the multiple perceptions of that entity (Bryman,
Events can be understood only when they are placed in the wider social and historical context. This study encompassed physical, social, and cultural contexts. The physical context entailed conducting the study in the geographical area of Amathole District Municipality, the setting being the homes, workplace, public health facilities, chemists or private accommodation where allopathic and traditional health practitioners practised their professions. The Amathole District Municipality is made up of five Local Service Areas or health sub-districts, namely, the Amahlathi, Nkonkobe, Buffalo City, Mbashe and Mnquma. The major towns in these Local Service Areas are Keiskammahoek, Alice, East London, Idutywa and Butterworth respectively. Participants in this study were drawn from these towns and their surrounding rural and informal settlement areas. The study was conducted in the context of an environment characterised by racial/cultural diversity, within the ambit of a culture peculiar to the Xhosa ethnic group and in the broader context of indigenous knowledge systems as practiced for decades by the black communities throughout the African continent. Furthermore, the study was conducted within the context of a healthcare delivery system that emphasises the primary healthcare approach.

A description of the research population, sampling method and sample size as well as data collection and analysis as applicable to this study follows.

2.5 RESEARCH METHODS

This study was conducted in two phases as was explained in Chapter 1. Phase 1 involved the exploration and description of the current nature of the relationship between traditional and allopathic health practitioners; their experience as role-players or stakeholders in the healthcare delivery arena in Amathole District Municipality, as well as their viewpoints with regard to the impact of legalisation of traditional medicine on their respective practices. Phase Two entailed development of strategies to facilitate collaboration between traditional and allopathic health practitioners to complement and optimise healthcare delivery.
The strategies for collaboration were based on the findings of Phase One and on information gathered through literature control and modified participant observation.

2.5.1 Phase 1: Data gathering and analysis
In collecting data there were a number of methodological criteria that the researcher had to follow as recommended by Mouton (1996:111). These included suspension of personal prejudices and biases, systematic and accurate recording of observations as well as creation of optimal conditions in terms of location and setting for collection of data. The aim was to produce reliable data.

2.5.1.1 Research Population
The research population is the entire set of objects, events or group of people having some common characteristics that the researcher is interested in studying (Bless & Higson-Smith, 2006:98). In this study, as was indicated in Chapter 1, the research population comprised three groups of health practitioners residing and working in the Amathole District Municipality, Province of the Eastern Cape. Group 1 comprised allopathic health practitioners. Group 2 consisted of traditional health practitioners while Group 3 was composed of participants trained as both traditional health practitioners and allopathic health practitioners. Because of a deficit encountered in Group 1 relating to the composition of its participants, a fourth group (Group 1a) was set up. Group 1a comprised allopathic health practitioners representing other health fields namely, pharmacy and medicine, racial group and clinical areas of operation. The rationale for establishing this group was to complement the shortcomings identified in Group 1.

The population, selection criteria, method of sampling, data collection and analysis for each group was as follows:
2.5.1.2 Group 1: Allopathic health practitioners

- Selection criteria

The research population for this group was set to comprise allopathic practitioners, namely, registered nurses, medical practitioners and pharmacists who were selected according to the following criteria. They were required to:

- have at least 2 years’ experience as a medical practitioner, registered nurse or a pharmacist;
- have worked either in a rural or urban public hospital, clinic or community health centre;
- be willing to participate and
- belong to any racial group, but should have provided healthcare services to the Xhosa communities

The reason for selecting registered nurses only and excluding the enrolled nurse categories was to avoid mixing people with different levels of expertise or authority. Because participants in this group were to take part in a focus group interview, a rank differential might have caused some participants to feel inferior and reluctant to contribute in the focus group interview (Kruger and Casey, 2000:27). The aim was, therefore, to create an environment where all participants would feel comfortable in expressing what they thought or felt.

- Sampling method

Sampling is the process of selecting a portion of the population that is representative of the target population (Mouton, 1996:110). Representativeness is the underlying epistemic criterion of a valid or unbiased sample (Mouton, 1996:110). Sampling involves a decision about which people, settings, events, and behaviours to observe (Terreblanche, Durrheim & Painter, 2006:49). The major reason for sampling is feasibility. Even if it were theoretically possible to identify, contact and study the entire population, the time and cost consideration would be prohibitive (Sapsford & Jupp, 2006:26).
Group 1 participants were selected through purposive sampling, which involves the conscious selection of certain subjects to include in the research project (Tashakkori & Teddlie, 2003:713). In qualitative research informants are purposefully selected because they might best answer the research question (Creswell, 2003: 185). Before beginning the interviews, Morse (1991:132) recommends that the researcher should decide who the most appropriate informants are. Purposive sampling demands that one thinks critically about the parameters of the population one is interested in, and chooses the sample because it illustrates some feature in which one is interested (Marshall & Rossman, 1999:104). In this study, the researcher used her judgement in selecting the participants that were representative of the topic being studied or who had information about the issue in question and were recognised as professional practitioners in their respective fields.

To get the participants for Group 1, the researcher contacted the manager for health services in the Amahlathi Local Service Area telephonically and discussed the study with her. The Local Service Area manager was informed that permission to conduct the study in the Amathole District Municipality had already been obtained from the Superintendent General for Health in the Eastern Cape Department of Health. The manager was then requested to allow the researcher to approach the nursing service manager of S.S. Gida district hospital in the Amahlathi Local Service Area for assistance in identifying doctors, registered nurses and pharmacists who were willing to participate in the study. The researcher approached the nursing service manager to explain the study and to forward a request for assistance. The researcher indicated to the nursing service manager her desire to recruit participants from a variety of clinical settings. This would provide richness of experiences on the nature of the relationship that had existed between traditional and allopathic health practitioners prior to legalisation of traditional medicine. Those willing to participate were requested to complete a form indicating their professional classification and experience in that field (See Annexure B). From the list of allopathic health practitioners who were willing to
participate as reflected in the completed form, the researcher purposively selected the participants that were representative of the various clinical areas. Because of the realities of staff shortages in the clinical area, on the day that the focus group interview was to be conducted, only six female registered nurses made themselves available. The situation was compounded by the arrival of a patient needing emergency care in the Out-patients Department just before starting the focus group interview. The only available doctor and pharmacist could therefore not participate in the focus-group interview.

- Sample size
The researcher had aimed at selecting at least one participant of each classification of allopathic health practitioner who met the selection criteria and ensured representation of gender and race, but on the day of the interview as already mentioned above, only 6 registered nurses arrived for the interview. They were all females, black and belonged to the Xhosa ethnic group. The predicament that the researcher found herself in, is highlighted in Barbour and Kitzinger's views (1999:8) when they stated that the precise composition of the groups was often a product of circumstances rather than planning.

- Data-collection method
In qualitative studies the researcher is the primary instrument for data collection and analysis. Data is mediated through this human instrument rather than through other instruments (Punch, 2006:52; Terreblanche, Durrheim & Painter, 2006:274). In this study, the data-collection method that was used for Group 1 participants was through a focus-group interview. A focus group interview can be described as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive non-threatening environment (Burns & Grove, 2005:737). It is a collectivistic rather than an individualistic research method that focuses on the multivocality of the participants' attitudes, experiences and beliefs (Denzin & Lincoln, 2000:836). Krueger and Casey (2000:24) recommend that focus group interviews should be considered when
the researcher is looking for a range of ideas or feelings that people have about something or trying to understand differences in perspectives between groups or categories of people. These authors further state that focus groups can uncover factors that influence opinions, behavior or motivation and provide insight into complex topics. They state that when one wants to pilot test ideas or policies, use of focus group interviews is advisable. Focus groups are characterised by the use of interaction between the participants, from which the researcher discovers how individuals think and feel about particular issues. Members of the group respond to the interviewer and to one another, asking questions, and commenting at one another’s experiences and points of view (Barbour & Kitzinger, 1999:4). Discussions in the groups might not only develop ideas, problems and questions which the researcher has not thought about before, but also find answers to some of these questions (Holloway & Wheeler, 1996:144). The ideas generated are normally analysed by qualitative methods. This method was chosen because focus groups are ideal for exploring people’s experiences, opinions, attitudes and concerns (Barbour & Kitzinger, 1999:5; Berg, 2004:126).

In the present study the researcher served as facilitator of the focus group and the following process was undertaken in planning and conducting the focus group interview.

- **Planning the interview:**
  As has already been explained, approval was obtained from the health services manager of the Amahlathi Local Service Area and the nursing service manager in charge of S.S. Gida hospital for the researcher to conduct the focus group interview at S.S. Gida hospital. The nursing service manager at S.S. Gida hospital acted as a gatekeeper by assisting the researcher in recruiting participants from different clinical settings or wards. She was guided by the recruitment letter from the researcher which detailed the aim and objectives of the study, and an attached form for completion by the participants indicating their biographical information, clinical setting in which they worked and willingness to
participate in the study. From the list the researcher purposively selected the participants and advised the nursing service manager about the names of those selected. While taking the issue of confidentiality into consideration, the researcher had to advise the nursing manager about the names of the participants so that their off duty times could be arranged accordingly. This was of particular importance in view of staff shortages in district hospitals in the Amathole District Municipality. Two days before the focus group interview the participants were reminded about the interview date and time through the nursing service manager. On the day of the interview, an official who had been assigned by the nursing service manager to arrange the venue and ensure the availability of the participants welcomed the researcher at the entrance to the administration offices.

- **Conducting the focus group interview**

The interview was conducted in a small but comfortable unused office in one of the wards at S.S. Gida hospital. This venue was very convenient as all participants were working in the same hospital which eliminated travel costs. The participants comprised six (6) black female registered nurses working in different wards at S.S. Gida hospital. Barbour & Kitzinger (1999:8) assert that bringing people together on the basis of some shared experience is often most productive although differences between participants are also illuminating. In this case the participants were working in the same hospital as registered nurses but in different clinical areas namely, medical, paediatric, maternity and Tuberculosis/TB wards as well as the Out-patients Department and the psychiatric clinic. The doctor and pharmacist were not available as requested. The number of participants was small enough to allow everyone to share experiences, opinions and insights but large enough to provide for diversity of perceptions (Krueger & Casey, 2000:10).

The researcher assembled and tested her tape-recorder and arranged the participants in a circle to facilitate voice capturing on the tape and eye contact
between the researcher and the participants. After introducing herself, the researcher welcomed and thanked the participants for making themselves available. The participants were provided with the context for the interview by briefing them about the research objectives, purpose of the interview, recruitment process, and the use of the tape-recorder as a tool to help capture everyone’s comments. They were further requested to complete a consent form to indicate their voluntary willingness to participate in the research study and were also assured about the confidential nature of the interview. The fact that they were free to withdraw from participating whenever they wished was highlighted. Questions from the group were adequately addressed.

The focus group interview was conducted in English, as all participants were able to speak the language and their lectures during their professional preparation were offered in English. As the researcher had no assistant, she had to take notes, be vigilant about the functionality of the tape and also observe non-verbal cues. Mental alertness on the part of the researcher was therefore crucial. In order to be in full control of the situation, the researcher requested that any participant wishing to contribute to the discussion should indicate it by putting up her hand. Unlike in individual interviews, the role of the researcher was that of a facilitator or group leader rather than purely an interviewer. After establishing ground rules, the focus-group interview was conducted using a discussion guide that had been prepared in advance to ensure that the appropriate topics were covered in the session and time limit determined for each topic beforehand. The topics in the guide related to:-

- the nature of the relationship that existed between allopathic and traditional health practitioners prior to the legalisation of traditional medicine as well as the experiences of medical practitioners, registered nurses and pharmacists as role players in the healthcare delivery landscape in the Amathole District Municipality;
the viewpoints of medical practitioners, registered nurses and the pharmacists regarding the impact that the legalisation of traditional healing would have on their practices and ultimately on service delivery; and
mechanisms that could be instituted to facilitate collaboration between allopathic and traditional health practitioners thereby optimising and complementing healthcare delivery.

The researcher tried to create a relaxed environment and encouraged discussion and expression of differing points of view. She emphasised that the idea of the focus group interview was not to reach consensus on the issues for discussion, but to elicit viewpoints. Therefore every participant’s views were important and had to be expressed freely. The importance of establishing a relaxed environment is embraced by Barbour and Kitzinger (1999:13) in their statement that the “freer” and more dynamic the situation of a focus group is, the better it will be to access “better data” than a subdued and formal encounter.

The researcher used an introductory question by asking the participants what came into their minds when they heard the word “traditional health practitioner”. The aim of asking an introductory question was to get clues about the participants’ views. Considerable time was consumed in deliberating on the key questions, namely, the impact that the new legislation on traditional health practitioners would have on the practice of allopathic health practitioners and the activities that had to be undertaken to facilitate collaboration between allopathic and traditional health practitioners in order to optimise and complement healthcare delivery. The researcher used probes and pauses to allow sufficient time for full discussion of these key questions. The discussion on the impact of legislation on the practice of allopathic health practitioners was, however, very superficial and the participants attributed this to a lack of knowledge regarding the contents of the Traditional Health Practitioners Act which was then Act 35 of 2004. The participants’ information about the Act was apparently limited to what they had heard in the radio and television discussions with no participation in
public hearings or exposure to consultation sessions over issues of traditional health practices.

In concluding the focus group interview, the researcher asked three types of final questions, namely, the “all-things-considered” question, the summary question and the final question (Krueger & Casey, 2000:45). The all-things-considered question is used to determine the final position of participants on critical areas of concern (Krueger & Casey, 2000:45). The question that the researcher asked was, “Of all the things that we have discussed, which one is most important to you?” This question allowed each participant to reflect on all comments shared in the discussion and then identify which aspects were most important and in need of action. In addition the participants may have shared inconsistent points of view and this question allowed them to clarify a position at the conclusion of a discussion. (Krueger & Casey, 2000: 46) state that the all things considered question is helpful in analysis because it is used to interpret conflicting comments and assigns weight to what was said.

The researcher then gave a short oral summary of the discussion evoked by the key questions. After the summary, participants were asked about the adequacy of the summary. The researcher enquired if she had correctly described what was said. The final question was an insurance question to ensure that critical aspects had not been overlooked. This final question started with a short overview of the purpose of the study and followed by asking the final question, “Have we missed anything?” Debriefing was then done with the researcher once more thanking the participants and providing them with her contact details. The researcher indicated to the participants the possibility of contacting them later when transcribing the interview to help clarify or verify a point that had been discussed. As a token of appreciation, the researcher provided snacks for the participants. The focus group interview lasted for 1 hour and 55 minutes with participants expressing excitement over the experience of being involved in such a lively discussion group. The tape and notes were labelled and dated. On her
way out the researcher was approached by one participant requesting to be
custed with a copy of the Traditional Health Practitioners Act as she had never
seen it.

- Reflecting about the interview

Schon (in Willis, 2007:204) advise that the researcher should engage in the
process of reflecting about the interview. This involves reviewing and analyzing
the interview process itself as it unfolds and recording these events in a personal
journal. Reflecting in action helps to assess the quality of data collected as
sometimes the interviewees may be off-topic. Reflection on action reviews the
actions the researcher has taken as well as underlying assumptions such as
whether the kind of data that the researcher is receiving is relevant to the study
or whether ethnicity of the researcher had an impact on the interviewees.
Reflection informs the researcher about the decision to take at each step and
gives qualitative research its strength and uniqueness as well as assuring its
methodological rigor (Willis, 2007:204). Without reflection and analysis, the study
may be unfocused and the amount of data collected overwhelming.

- Data Analysis

Data analysis is conducted to elicit meaning from the collected data in a
systematic, comprehensive and rigorous manner. This is done by organizing,
reducing and describing the data (Henning, Van Rensburg & Smit, 2004:127).
The tape-recorded focus-group interview was transcribed verbatim and the
transcription was utilised as the database for the study. This was analyzed using
Tesch’s method as described by Creswell (2003:192) to identify themes and sub-
themes. The cognitive strategies that were used in analysing the data were
inductive reasoning, synthesis, bracketing and intuition. Through inductive
reasoning an attempt was made to discover relationships or patterns through
close scrutiny of the data. The data was analyzed and interpreted by means of
inductive abstraction and generalisation (Masson, 202:180). Synthesis was used
to identify relationship between concepts and categories. The researcher also
identified what she expected to discover in this study and then deliberately put this idea aside. This is called bracketing, which allows a person to unknow her/his experiences and enter the life-world of another person (Beech, 1999:36). It is a process by which the researcher resolves to hold all preconceptions in abeyance in order to reach experiences before they are made sense of or before they are ordered into concepts that relate to previous knowledge and experiences (Beech, 1999:36). Since the researcher is trained as a registered nurse and also grew up and worked in the Amathole District Municipality, the researcher has had her own encounters with traditional healers. The researcher thus had to unknow or bracket all these experiences and what she had previously read about traditional healers and focus only on what she heard from the participants.

The researcher took the information from the focus group interview and reduced it to certain patterns, categories or themes and then interpreted it by using a schema. Tesch (in Cresswell, 2003:192) called this process “decontextualisation and re-contextualisation.” There are flexible rules that govern how one goes about sorting through interview transcriptions, observational notes, documents and visual material. Categories or themes were identified by using Tesch’s method of descriptive analysis. Categories of information were formed and codes attached to these categories. Coding is the process by which concepts or themes are identified and named during the analysis. The researcher used both open coding which is the process of breaking down and conceptualizing the data; and in vivo coding which consisted of words and phrases used by the participants themselves to describe a phenomenon (Denzil & Lincoln, 2000, 2000:783). These codes and categories formed the basis for the emerging story to be told by the researcher (Creswell, 2003:192).

Descriptive analysis was done in this study using the eight steps recommended by Tesch (in Cresswell, 2003:192) to engage the researcher in a systematic process of analyzing textual data.
To analyse the data the researcher:

- read through all the transcripts carefully, jotting some ideas down as they came to mind in order to get a sense of the whole;
- picked the most interesting script and the shortest, went through it asking herself what it was all about and thinking about the underlying meaning, and also writing thoughts in the margin;
- made a list of all topics after following the procedure stated above with all the information; clustered together similar topics and arranged them into columns under major topics, unique topics and leftover topics;
- took the list and went back to the data, abbreviated the topics as codes and wrote the codes next to the appropriate segments of the text; and assessed the preliminary organising scheme to see whether new categories and codes emerged;
- turned the most descriptive wording for the topics into categories; grouped together the topics that related to one another; drew lines between categories to show interrelationships;
- made a final decision about the abbreviation for each category and alphabetized the categories;
- assembled the data material belonging to each category in one place and performed a preliminary analysis; and
- recoded existing data as the need arose.

In order to ensure trustworthiness of the study, the transcribed focus group interview was sent to the study promoter and co-promoter who are experienced in qualitative research and in possession of doctoral degrees. A meeting was arranged between the researcher and her study promoters to discuss and reach consensus on identified themes.
Group 1a: Allopathic health practitioners belonging to other health fields

Group 1a was not an intentionally planned group, but established circumstantially to address a deficit encountered in Group 1 on the day of the focus group interview. Group 1 was initially intended to be a heterogenous group of allopathic health practitioners reflecting representivity in terms of gender, ethnicity and professional preparation. This could not be achieved due to circumstances prevailing in the clinical area at S.S. Gida hospital on the day of the focus group interview as has already been stated in the text. Through reflection in action, the researcher decided to set up Group 1a comprising participants who met the selection criteria. The aim was to complement the allopathic health practitioners’ viewpoints by including participants belonging to other health fields and racial groups. This decision was taken after the researcher had discussed her predicament with her study promoters. The researcher deliberately avoided forming Group 1a into a focus group for the relevant interview in anticipation of the difficulty that might be experienced in bringing these health workers together at a central venue at the same time. The researcher had observed the reality of extreme shortages of doctors and pharmacists in the clinical areas. The most realistic method of collecting data from this category was therefore through individual interviews by making use of the available time for each participant. The researcher wants to reiterate the fact that formation of Group 1a was not pre-planned but addressing a shortfall which would create an impression that ideas expressed by participants in the focus group interview were those of allopathic health practitioners, whereas in reality they were from registered nurses only. Having set up this group meant therefore, that the views of allopathic health practitioners would be those of Group 1 (Focus Group Interview) plus Group 1a (Unstructured individual interviews).

- Selection criteria

The selection criteria for Group 1a were the same as in Group 1.
• Sampling method
Purposive sampling was used to recruit participants for this group. Participants were handpicked by the researcher from the Buffalo City Local Service Area for inclusion into the study. A written request was e-mailed directly to each participant followed by a telephonic explanation of the contents of the request. All four participants were enthusiastic about participating. They were informed that prior approval had been obtained from the Superintendent General of the Eastern Cape Department of Health and that they had to sign a consent form to indicate their voluntary willingness to participate in the study.

• Sample size
At least one participant of each classification of allopathic health practitioner who met the selection criteria was selected and representation of gender and racial group was ensured. Of the four participants selected, two were white, one coloured and one black. There were two males and two females, one medical doctor, a pharmacist and two nurses with experience in trauma care and community health services. Details are reflected in Table 3.7 in chapter 3.

• Data collection
Data was collected by means of unstructured individual interviews using a tape recorder. The interviews were conducted in English in the participant’s workplace and lasted for 45 minutes to an hour. Participants were asked the same questions as those posed to other groups. The interviews were disconnected when saturation was reached after four participants were interviewed. Saturation is a term used to describe the point when one has heard the range of ideas and is not getting new information (Krueger & Casey, 2000:26).

• Data analysis
Analysis began on the day following data collection. The process of analysis started with the transcription of the tape-recorded data which corroborated with
field notes. Data analysis was conducted in the same manner as was described for all other three groups.

2.5.1.3 Group 2: Traditional Healers

- **Selection criteria**
  The selection criteria for Group 2 participants were that the person was:
  - either a diviner, traditional doctor/herbalist, traditional birth attendant or traditional surgeon;
  - willing to participate;
  - had at least 2 years’ experience in the particular speciality as a traditional healer;
  - was practising from either a home or private accommodation; and
  - belonged to the Xhosa ethnic group and was able to communicate in isiXhosa

- **Sampling method**
  As in Group 1 the sampling method for Group 2 participants was purposive sampling. Purposive sampling is based on the assumption that a researcher’s knowledge about the population can be used to handpick the cases to be included in the sample (Berg, 2004:36). Patton (2002:46) advises that the researcher has to identify “information-rich” cases, that is, those from whom one can learn a great deal about the issues of central importance to the purpose of the research. The question that she advises the researcher to ask is, “who has the greatest amount of insight on this topic?” The researcher requested the Provincial Co-ordinator for the affairs of traditional healers telephonically to assist in identifying traditional healers residing and practising in the Amathole District Municipality. As the researcher also lives in the Amathole District Municipality, she knew the names of some of the healers; but the difficulty was how to contact them. The co-ordinator provided the researcher with the telephone numbers of the practitioners and the name of the clinic or shop nearest to the home of the practitioner. From the list of these traditional healers the researcher used her
judgement in selecting the participants who were recognized as traditional healers in their respective fields. If the researcher was not familiar with the traditional healer’s name, she would enquire from the clinic nurses in that area the level of recognition, acceptance or popularity of that particular traditional health practitioner before setting up an appointment with him or her. In view of the distance to some of these areas, the researcher had to telephone the shop owners or clinic nurses to set up an appointment with the practitioners in cases where traditional healers did not have cellular phones. Relaying messages through shop owners and clinic nurses is a normal and relatively reliable communication method among the black communities living in this area.

The telephonic conversation was followed by a written request to participate, written in isiXhosa, as well as an informed consent form to be completed by those willing to participate (See Annexure C and Annexure D). All the letters requesting participation were hand-delivered using the nursing staff working in mobile clinics and clinics in those areas and in one instance a taxi drivers was also used. The diviners were specifically requested to appeal for approval to participate from their ancestors on behalf of the researcher. This was done to guard against the ancestors disapproving or alleged to be disapproving of participation on the day of the interview.

- **Sample size**
At least three participants of each type of a traditional healer who met the selection criteria were included in the study. The sample size was determined by the principle of data saturation (Krueger & Casey, 2000:26). This meant that when the researcher found no further explanation, interpretation or description of the phenomenon being studied from different participants, saturation of data was reached and efforts to obtain participants to include in the sample were discontinued.
• Data-collection method

Data was collected from the traditional healers by means of unstructured individual interviews, field notes, and modified participant observation. An unstructured interview is selected when one wants to obtain an in-depth, dense description and understanding of the participant’s world (Tutty, Rothery & Grinnell, 1996:56). The aim of using an unstructured interview is to elucidate the respondents’ perceptions of the phenomenon without imposing any of the researcher’s views on the participants. Interviews were conducted in isiXhosa in the home or work situation of each traditional healer—a naturalistic setting. Use was made of an interview schedule.

The schedule contained the following 3 broad questions that were pertinent to the study and which were posed to each traditional healer who participated in the study:

- As a traditional healer who has worked in the same communities where allopathic and other traditional health practitioners also performed their duties, what was the nature of your relationship with these health practitioners before legalisation of traditional health practitioners? Just share your experience.

  Njengenyangi yemveli ebisebenza phakathi koluntu apho neenyangi ezinyanga ngokwasemzini nangokwemveli bezisebenza khona nazo, ngexesha ubungekaphunyezwa lo mthetho ulawula iinyangi zemveli, ingaba ibinjani intsebenziswano yakho nazo? Kha utsho amava akho.

- How is the new legislation on traditional health practitioners going to impact on your practice?

  Ingaba lo mthetho mtsha ulawula iinyangi zemveli uzakuyimisa njani indlela osebenza ngayo?
What mechanisms can be instituted to assist in the development of strategies to facilitate collaboration between traditional and allopathic health practitioners in order to optimise and complement healthcare delivery?

Kungasetyenziswa mingxilo mini ukudala intsebenziswano phakathi kwabanyanga ngokwemveli nabanyanga ngokwasemzini ukuze kuphuhliseke impilo yoluntu?

These questions were asked in isiXhosa and were not necessarily asked in the same sequence. As a researcher coming from the same cultural background as the participants the researcher had to be specifically cautious when interviewing the diviners by using the salutary term “Camagu Mhlekazi” when greeting or thanking them or encouraging them to continue talking. This jargon, “Camagu Mhlekazi” (may your ancestral spirits be appeased, Your Worship!) is basically a way of showing respect and gratitude. In order to stimulate and motivate the interviewees to participate spontaneously, the following communication techniques were used:

- Minimal verbal response
  The researcher adopted a fairly passive role and allowed more time for the participants to talk by using responses like “uhm, ewe (yes) and “Camagu.” This communication technique was of importance because there is a dearth of knowledge regarding traditional healing and information had to be allowed to flow from the traditional health practitioner’s side.

- Silence
  Sometimes the researcher refrained from responding after the participant had made a comment. In this way the participant was unobtrusively prompted to give more information. Use of pauses in the conversation allowed the participants ample time to associate and reflect on the content and then broke the silence themselves with significant information (Kvale, 1996:135).
Probing
Probes are additional prompting questions that encourage the respondent to elaborate on the topic that is being discussed (Brink, 2006:207). The researcher pursued the given answers, probing their content without stating what dimension was being taken into account (Kvale, 1996:133). General tactics such as use of enquiring glance or repeating all or part of the interviewee’s response were used as probes.

Clarifying
If a participant’s response was vague, unclear or confusing, the researcher requested clarification by asking the participant to tell her more about an issue. By making a guess regarding the participant’s basic message and requesting clarification, the researcher brought vague statements into sharper focus.

Summarising
In order to ensure that she had correctly captured what the participants had said, the researcher had to repeat in her own words the ideas, opinions and feelings of the participants especially when interviewing diviners as they have their jargon. She had to ask “ndikuvu kakuhle xa ndisithi wena uthi? (Do I hear/understand you correctly when I say you are saying?)”

Building Trust
The need to build trust and establish rapport was crucial because the study was conducted at the time that the South African Government was introducing registration of all traditional health practitioners as a step towards the acceptance and recognition of their practice. Not all traditional health practitioners welcomed the idea of registering in order to practise, as this was interpreted as a ploy by the government to force them to divulge their knowledge of medicinal plants. They thought that this knowledge would probably be stolen by the government and its western-trained healers. The participants were thus skeptical about the
researcher’s visit. To illustrate this point, in one of the herbalist’s home, his wife, a diviner, came to the hut where the interview was being conducted with her husband and vigorously swept the dusty mud floor causing the researcher to sneeze and cough. This type of behaviour is not normally displayed towards visitors in the Xhosa culture and it was clearly an indication of being made to feel unwelcome by the obviously suspicious wife. Ironically, the husband was enthusiastically sharing his views with the researcher.

Mutual trust not only ensures the co-operation of the participants but also improves the quality of collected data (Denzin & Lincoln, 2000:655). In order to build a relationship of trust, the researcher had to treat the participants with courtesy and empathy. Denzin and Lincoln (2000:655) advise that in order to gain trust and establish rapport, the researcher must be able to take the role of the respondents and attempt to see the situation from their viewpoint rather than superimpose his or her world of academia and preconceptions upon them.

As anxiety was much pronounced among traditional birth attendants, the need to build trust was greater than with other traditional healers. At the commencement of the interview two of the participants were so anxious that they had organised neighbours to be present as witnesses during the interviews to detect statements that could implicate the participants. When the researcher requested them to relax and explained the aim of research, they commented that they feared being arrested, quoting instances where traditional surgeons had been arrested by the government for illegal practice, botched circumcision and deaths of initiates. The information about arrested traditional surgeons was apparently heard over the radio, television and local newspaper. To put the participants at ease, the following approach was adopted:

- On entering the house of the participant, the researcher announced her presence in a manner typically used by rural communities by saying
“knock, knock, knock, here’s a person” (*Nkqo, nkqo, nkqo, nank’umntu*) and used a handshake to greet everybody in the participant’s home

- In introducing herself, the researcher emphasised her clan, that of her mother and those of her maternal and paternal grandmothers. This had a significant effect in creating a relaxed atmosphere as some participants shared these clan names with the researcher through their mothers, grandparents and in-laws. In the Xhosa culture clans form a basis for social relationships and play an important part in the traditional healing as ancestors of a particular clan of the patient are invoked during divination and treatment.

- The diviners were greeted in the customary unique manner using the salutary phrase “*Camagu Mhlekazi.*”

- The researcher carefully explained the purpose of her visit as a follow-up of her previous correspondence regarding her study, its aim and objectives and the reason for using a tape-recorder. She further read out the contents of the consent form, invited questions and clarifications and then requested them to sign the consent form as an indication of voluntarily agreeing to participate in the research study. The researcher also clarified that she was interested in their experiences and viewpoints rather than in the traditional medicines that they were using. Signing a consent form met with some resistance and suspicion but through exhaustive explanation of the rationale thereof, the participants willingly agreed to participate.

- The researcher impressed on the participants that they had been handpicked to participate in the study specifically because of their expertise, and the high regard that communities had for them. Their input would therefore add value in developing strategies to facilitate collaboration between traditional and allopathic health practitioners. They were informed that they were, however, free to withdraw if they so wished. The researcher noted that the idea of being highly esteemed by the communities developed rapport judging by the smiles and laughter and
renewed eagerness to participate. It was at this juncture that most of the participants would freely express their initial reservations relating to arrest. It has to be pointed out though, that the aim of the researcher was not to manipulate them psychologically to participate, as this would be contrary to the ethical principles of research. The idea was to impress that obtaining viewpoints from experienced traditional health practitioners rather than novices was crucial and of benefit in the study.

In analysing and reporting on data gathered through interviews, the researcher is expected to quote the response in the text verbatim (Polit & Hungler, 1991:282). For that reason each interview was tape-recorded. Tape-recording is the best way to ensure full transcription of an interview and to capture the richness and subtleties of the speech of the person being interviewed (Tutty, Rothery & Grinnel, 1996: 67). As an aspect of ethical consideration, the researcher had already indicated to the participants earlier on that the interview would be tape-recorded and the objective thereof was stated. Interviewing was terminated when theoretical saturation had occurred, that is, when sufficient data had been collected and no new themes were emerging (Terreblanche, Durrheim & Painter, 2006:372). Participants were thanked for their time and willingness to take part in the study and share information. Debriefing was done and participants were informed how to contact the researcher should they have any queries. The researcher indicated that she might return or telephone to clarify or confirm a point raised by the participant during the interview. Verbatim transcripts of each interview were made a day or two after the interview.

Field notes

Field notes and a personal journal were kept reflecting non-verbal communication that was observed during the interview. The tape recorder misses the smells, impressions and body language of the participant as well as extra remarks made before and after the interview. The researcher also needed a system for remembering observations, and retrieving and analysing them (Wilson,
For that reason the researcher’s account of what she heard, saw, experienced and thought in the course of collecting data was entered in a personal journal or field notes. Field notes consist of two kinds of material. The first is descriptive in that the concern is to capture a word-picture of the setting, people, actions and conversations observed whereas the other is reflective, that is, the part that captures more of the observer’s frame of mind, ideas and concerns (Field & Morse, 1990:79-82). Field notes were recorded in a format that categorised the information into observational, methodological, theoretical and personal notes to give completeness and coherence.

- **Observational notes**
  These are descriptions of the events as experienced through watching and listening. They contain the “who, what, where and how” in a situation and as little interpretation as possible (Wilson, 1993:222). In this study observational notes reflected on what was observed regarding the appearance of the traditional health practitioner, non-verbal communication, events and the appearance of the consulting area. The following observations were noted by the researcher:-

  - Traditional healing, specifically divination and to some extent herbalism, ran in families

  - A distinct trend was noticeable in the general appearance of the traditional healers’ homes. The educated healers irrespective of the geographical area, had neat, well-constructed and comfortable homes, but the homes of the illiterate or poorly-educated healers tended to be poorly constructed mud houses some in unhygienic condition. In one homestead the researcher had to sit on a bare bed frame for the entire hour of interviewing as the only available chair was used by three ladies who were waiting to be attended to by the healer in another hut.

  - The herbs used by the traditional health practitioners were kept in a special room or hut called “umrawule.” Some were labelled in bottles and put on shelves
or on the floor. Roots and pieces of bark were displayed on the floor. Some were so dry and dusty that the ability to recognise them was questionable.

- In one home, the researcher conducted the interview under much strain of inhaling strong fumes from a strong smelling herb that was burned on a small piece of zinc sheet over a primus stove. On seeing the researcher the participant in this home quickly went to his bedroom and came out clad in a black academic gown. The reason for this was not explained. The researcher phoned the participant after three weeks to establish the reason for wearing the black robe during the interview.

- In one of the participant’s homes a young mentally disturbed man in his twenties was roaming around the yard with both legs chained together. The patient was allegedly suffering from “amafufunyana” and had been brought by his mother to the diviner.

- Theoretical notes
  Theoretical notes are purposeful attempts to derive meaning from the observational notes (Wilson, 1993:222). In this study the researcher made her own interpretations and inferences to build her analytical scheme.

- Methodological notes
  Methodological notes are instructions to oneself, critiques of one’s tactics and reminders about methodological approaches that may be fruitful (Wilson, 1993:222). Because the field of traditional medicine has not been researched enough in the Amathole District Municipality, the researcher had to be vigilant not to be derailed by the emergence of other interesting statements made by the participants during the interview. The possibility of being overwhelmed by details pertaining to how the traditional health practitioners acquired their skills (details of the “thwasa” process), how they reached a diagnosis and the healing methods they used, was a real threat. The researcher had to remind herself constantly
about the aim of the study, the design and the methodology that she had planned to pursue. However, statements made by the healers which could serve as critical elements in the development of strategies to facilitate collaboration between traditional and allopathic health practitioners, were elucidated.

- **Personal notes**
  Personal notes are notes about one’s own reflections and experiences (Wilson, 1993:223). By keeping personal notes the researcher gained increased insight into the experiences being studied. The researcher reflected on the emotions she experienced before, during and after the interview. The emotions ranged between fear, doubt and curiosity. Feelings of fear were experienced, especially in the homes of diviners and herbalists with displays of dolls dressed in traditional healer garb, snake-skins, animal skeletons, horns and hides of wild animals. A feeling of pity mingled with doubt was aroused by observing how some diviners appeared to be so "possessed by or obsessed about ancestral spirits" that they tended to interpret almost all their actions in their daily living as being obeying directives from the ancestors—a suspension of their own individual thought processes.

It was also interesting to reflect on the power or influence of culture on an individual. This statement specifically relates to the feelings of uneasiness experienced by the researcher at the thought of the possibility of the diviner’s ability to read the researcher’s doubts when the diviners marketed their skills and made weird claims of their ability to cure a range of diseases.

- **Data collection through modified participant observation**
  It was indicated earlier on in this study that participant observation would be done to collect more data that may assist in developing strategies to facilitate collaboration between allopathic and traditional health practitioners to enhance healthcare delivery. The weakness of this method is that researchers risk losing their objectivity. Being directly involved with people and their daily concerns for
an extended period of time may predispose one to be emotionally involved and thus lose detachment from the people and events. Also because notes have to be taken down unobtrusively or from memory, inaccurate information may be recorded. Because participant observation is a time-consuming activity involving extended periods of residence among the participants, a modified participant observation method was used (Bless & Higson-Smith, 2006:115). In this method participation is restricted to major events. Consequently, participation in this study was restricted to selected rituals, activities and ceremonies as described below.

- Attendance at a séance (*intlombe*)

One of the ceremonies attended by the researcher was the séance (*intlombe*) held in Buffalo City in December 2005. This is a ritual characterised by singing, clapping of hands and performance of a special stamping dance (*Ukuxhentsa*). This was specifically held to induct a newly qualified diviner but the ceremony is not confined to this purpose. At the height of the singing and dancing one of the traditional healers entered into a trance and pounced upon one lady among the audience making an impromptu diagnosis of that lady’s illness and social problems. The issue of confidentiality crossed the researcher’s mind as the ailments and social problems of this lady were publicly disclosed. This, however seemed not to bother the affected lady, judging from her constant nodding in apparent agreement with the statements made by the healer.

In participant observation the observer to some extent hides his/her presence by becoming a participant. She/he joins the group that is being explored as one of its members, sharing all activities. Becoming an insider allows a deeper insight into the specific phenomenon since one enjoys the confidence of the participants and shares their experiences without disturbing their behaviour. The role that was assumed by the researcher in this study was the concealed participating observer role (Yegidis & Weinbach, 1996:151). The researcher participated in the singing and clapping of hands only, while observing all health-related procedures
and activities that were being performed that could assist in the development of strategies to facilitate collaboration between traditional and allopathic health practitioners. Attendance at a séance by community members is not per invitation. Anybody is free to attend. By not revealing the researcher role, therefore, the researcher cannot be regarded as having violated an ethical principle.

- Attendance at a cleansing ceremony

Another ritual attended by the researcher was a cleansing ceremony conducted at Vlakplaas in Gauteng Province in December 2003. Traditional healers from the nine provinces of South Africa participated in this ceremony. The researcher had the opportunity of travelling with delegates (traditional healers) from the Eastern Cape Province. During that journey the researcher made some observations which could have a bearing on the development of the strategies to facilitate collaboration between allopathic and traditional health practitioners. The researcher noted the degree of modernisation that had already taken place among traditional healers. This assumption was based on their use of cellular phones as communication tools and attention paid to personal hygiene (mouth washes and use of body perfumes). Traditional healers, especially diviners, were previously notorious for neglecting their physical appearance. They generally had offensive body smell and long, braided and unkempt hair. A link between religion and traditional healing was also noted by the researcher. For example, before departure to Vlakplaas the delegates prayed to God (not ancestors) for a safe journey and on arrival, a short service thanking Him for safe arrival was held. The value attached to a clan was also noted because throughout the journey, all those who chatted with the researcher enquired what her clan was and did not bother about her name or surname. This reminded the researcher that traditional healers always invited the presence of the client’s ancestors calling them by their clan names whenever they conducted divination, a ritual or provided treatment.
Participation in a conference on traditional medicine

The third major event that the researcher participated in was a conference on operationalisation and institutionalisation of traditional medicine that was held at the Kopanong Conference Centre in Benoni on 9-10 June 2006. Deliberations in this conference highlighted issues pertaining to traditional medicine that could serve as a reference point when developing the proposed collaboration strategies. These issues related to the legal framework and regulations for traditional medicine, collaboration linkages, education and training in traditional medicine, research and development in traditional medicine, local production of traditional medicine and sustainability of traditional medicinal plants.

Permission to attend the conference and the cleansing ceremony was obtained from the organisers of these events in the National Department of Health and facilitated by the Provincial Co-ordinator for the affairs of traditional healers. At both events, the researcher role was disclosed. Participation in the selected activities extended over a period of four years. Fieldnotes were made of those critical events to enrich the data and derive meaning from the occurrences.

Data Analysis

The tape-recorded interviews were transcribed verbatim and the transcriptions were utilised as the database for the study. The researcher reduced the data meaningfully until the central storyline as told by the traditional health practitioners emerged clearly. Data was analysed according to the descriptive analysis method by Tesch (in Creswell, 2003:192). Themes and sub-themes were formulated in the same manner as was explained for Group 1. In order to ensure trustworthiness of the study, the raw data was also sent for analysis to a Xhosa-speaking independent coder who was knowledgeable in the field of qualitative research. The independent coder was given a clean set of transcripts as well as a guideline of how the data was analysed. A meeting was arranged with the independent coder for consensus discussion on the themes and categories reached independently. Although the researcher and the independent coder...
coder based their discussion using transcripts that were recorded in isiXhosa, the themes were identified in English and verified by the Xhosa speaking independent coder. This was done to guard against losing the essence of what had been said by the participants.

2.5.1.4 Group 3: Nurses who are also traditional healers

- Selection criteria

The selection criteria for the participants with dual qualification as allopathic health practitioners as well as traditional healers were that he/she was:
- a registered or enrolled nurse but also practising as a traditional healer;
- willing to participate in the research project;
- a nurse and a traditional healer in his/her speciality for at least 2 years;
- practising at home, in a public health institution or private accommodation; and
- belonging to the Xhosa ethnic group

- Sampling Method

Snowball sampling was undertaken to select the nurses who also practised as traditional healers. Snowball sampling is the selection of participants by means of referrals from earlier participants. This means that when the researcher has found a few participants with the required criteria, he/she will ask their assistance in getting into touch with others having similar characteristics. This method of sampling is most often used when the population consists of people with specific traits who might be difficult to identify by ordinary means (Polit, Beck & Hungler, 2001: 236).

In this study the researcher knew of two nurses in the Amathole District Municipality who were also traditional healers. A written request was sent to each participant and an informed consent form to be completed by those willing to participate (See Annexure D & Annexure E). The written consent form was in English as the nurses could read and speak English. The two
nurses were each requested to supply the names of other nurses who were also traditional healers and met the selection criteria. The additional nurses were approached, requested to participate and to sign the consent form. The number of participants was increased until theoretical saturation was reached.

- **Sample Size**
Sampling to redundancy was done. This involves not defining one’s sample size in advance, but interviewing more and more people until the same themes and issues come up over and over again. The sample has achieved redundancy in the sense that no new information can be gained from increasing the sample size (Terreblanche, Durrheim & Painter, 2006:50). The sample size was concluded after four participants had been interviewed and no new information was emerging.

- **Data collection method**
Data was collected from the nurse/traditional healer participants in Group 3 by means of unstructured individual interviews and field notes. These were held in the homes of each traditional healer-a naturalistic setting. Just before commencement of the interviews, one participant knelt before her chemist - “umrawule”, reported the presence and the purpose of the visit of the researcher to her ancestors, calling them by their clan names and appealed to them to accept the researcher. Thereafter she invited the researcher to the room where the interview was going to be conducted. A similar ritual was observed by the second participant. The researcher was taken to the back of the house facing a cliff to have her visit announced to the participant’s ancestors. After calling her ancestors by their clan names requesting them to accept the researcher in the household about four hadedas appeared and flew across the cliff to the delight of the participant who excitedly pointed at the birds stating “there they are (ancestors); so you’ve been accepted in this home. Let’s go inside the house.”
Although the participants were able to speak English, the interviews were conducted in isiXhosa to accommodate the culturally rooted jargon of traditional healers. The following 3 broad questions that are pertinent to the study were posed to each nurse/traditional healer who participated in the study:

- As a nurse and traditional healer who has worked in the same communities where allopathic and traditional health practitioners also performed their duties, what was the nature of your relationship with these health practitioners before legalisation of traditional healers? Just share your experience.

Njengenyangi yemveli ebisebenza phakathi koluntu apho neenyangi ezinyanga ngokwasemzini nangokwemveli bezisebenza khona nazo, ngexesha ubungekaphunyezwa lo mthetho ulawula iinyangi zemveli, ingaba ibinjani intsebenziswa yakho nazo? Kha utsho amava akho.

- How is the new legislation on traditional health practitioners going to impact on your practice?
  Ingaba lo mthetho mtsha wona ulawula iinyangi zemveli uzakuyimisa njani indlela osebenza ngayo?

- What mechanisms can be instituted to assist in the development of strategies to facilitate collaboration between traditional and allopathic health practitioners in order to optimise and complement healthcare delivery?
  Kungasetyenziswa mingxilo mini ukudala intsebenziswa phakathi kwabanyanga ngokwemveli nabanyanga ngokwasemzini ukuze kumphuhliseke impilo yoluntu?
Each interview was tape-recorded. Verbatim transcripts of each interview were made and transcribed into isiXhosa but only the themes were translated into English. Field notes and a personal journal were kept reflecting non-verbal communication that was observed during the interview.

- Data Analysis

Data collected from the four nurses who were also traditional healers was analysed in the same manner as was described above in Group 2.

2.5.1.5 Pilot Study

Pilot studies are carried out to assess the feasibility of a research project, the practical possibilities to carry it out, the correctness of some concepts, and the adequacy of the method and instrument of measurement (Bless & Higson-Smith, 2006:60; Van Ort in Brink & Wood, 1998:379). Before undertaking the pilot study the researcher had discussion with her promoters regarding the clarity of the research questions and the interview technique to be used. A pilot study was undertaken in this research project by conducting an interview with a traditional healer (herbalist) residing in the Amahlathi Local Service Area who met all the sample selection criteria and who was not going to participate in the main study. The interview was transcribed and analyzed in the planned manner to determine whether themes could be identified (Grove, Burns & Hegstad, 1993:19). The identified themes were integrated with those of other traditional health practitioners.

2.5.1.6 Literature Control

A literature control contributes to the trustworthiness of a research study through confirmation of findings (Creswell, 2003:31). In qualitative studies, literature is reviewed early as an orienting framework, in other words it is used to “frame” the problem (Cresswell, 2003:30-31). This entails providing a backdrop to the problem by indicating who has studied the issue, who has written about it and who has stated the importance of studying the issue. Literature
can also be incorporated in the final section of the study where it is used inductively to compare and contrast with the results or themes that emerged from the study (Burns & Grove, 2005:95). In the current study literature was reviewed to frame the problem, during the discussion of the proposed strategies and to recontextualised the findings within credible existing literature. The reader will note that in certain cases reference is made to old literature; the reason being that traditional healing is rooted in culture; and culture is as old as mankind. In addition the researcher wanted to highlight the fact that the issue of establishing a working relationship between allopathic and traditional health practitioners has been a subject of discussion for more than three decades, but has not been resolved. The current study may assist in uncovering certain elements hindering that process. Literature was also studied to gather data that could be used in developing the strategies for collaboration between allopathic and traditional health practitioners.

2.5.2 PHASE 2: DEVELOPING STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

Phase 2 of the study entails development of strategies to facilitate collaboration between allopathic and traditional health practitioners to complement and optimise healthcare delivery. The strategies are based on data obtained from the interviews, fieldnotes and participant observation as highlighted in Chapter 3. The theoretical framework that guides the development of these strategies is the Survey List drawn up by Dickoff, James and Wiedenbach (1968:423). Guided by the survey list, the aspects that are addressed relate to who implements the strategies, that is, establishing the agent(s); who are the recipients of the strategies and what is guiding the implementation of the strategies in terms of legislation, procedures and protocols. The survey list also outlines the environment or context in which strategies are implemented. The factors that may inhibit or promote the successful implementation of the strategies are also outlined. Above all the Survey List allows for an indication of the terminus or
ultimate goal of the proposed strategies which is effective collaboration. The Survey List is detailed in Chapter 4 and a comprehensive description of the strategies is dealt with in Chapter 5.

2.6. TRUSTWORTHINESS OF THE STUDY

The worth of any research endeavour regardless of the approach taken, is evaluated by peers, grant reviewers and readers (Krefting, 1991:214). In quantitative research, the worth of a project is recognised by assessing the reliability and validity of the work. A model for assessing the trustworthiness of qualitative data was proposed by Guba, whose model (in Krefting, 1991:214-222) is based on the identification of four criteria of trustworthiness, namely, truth value, applicability, consistency and neutrality. The model defines different strategies of assessing these criteria in each type of research. These strategies assist the researchers in designing means for increasing the rigour of their qualitative studies and also for the readers to use as a means of assessing the value of the findings of qualitative research. In this study trustworthiness was ensured by using Guba’s model of trustworthiness (Krefting, 1991:215).

Truth value establishes how confident the researcher is with the truth of the findings based on the research design, informants and context (Krefting, 1991:216). The strategy used to ensure truth value is credibility which refers to the truth as known, experienced or deeply felt by the people being studied and interpreted from the findings of co-participants’ evidence as the “real world” or the truth in realities. This includes subjective, intersubjective and objective realities. Etic or outsider’s views are studied in relation to emic perspectives (Morse, 1994:105). Credibility requires adequate submersion in the research setting to enable recurrent patterns to be identified and verified (Krefting, 1991:216). Use of a tape recorder to obtain accurate information and contextual validation helped to increase credibility of the study. Some of the strategies that were used by the researcher in this study to increase credibility include triangulation, peer
examination, member checking, prolonged and varied field experience, structural coherence and pilot interviewing.

Triangulation is a process of using multiple methods of data collection with a view to increasing the reliability of observation (Robson, 2002:174; Willis, 2007:218). Triangulation is based on the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated. The triangulated data sources are assessed against one another to cross-check data and interpretation. The underlying assumption is that, because various methods complement each other, their respective shortcomings can be balanced out (Tashakkori & Teddle, 2003:705). In this study triangulation of data sources was done by conducting unstructured interviews with different types of traditional healers, namely, traditional birth attendants, traditional surgeons, herbalists and diviners; holding a focus-group interview with a variety of allopathic health practitioners with varying years of practice and conducting literature control. Triangulation was further done through participant observation and by using independent coders to reach consensus on the themes that emerged.

Peer examination was done to increase credibility. This entailed discussing the research process and findings with other impartial colleagues who had experience with qualitative methods and who were able to increase credibility by checking categories developed out of data and by looking for disconfirming or negative cases (Krefting, 1991:219). The use of peer groups can contribute to preventing researcher bias and can have a valuable therapeutic function. As research can be extremely demanding and stressful for the researcher, peer group can help the researcher to cope by supporting and encouraging him/her (Robson, 2002:175). In this study peer examination was done by using independent coders who were provided with verbatim accounts or transcripts of interviews. One independent coder was specifically chosen on the basis of her knowledge of qualitative design and the isiXhosa language as well as proximity.
My study promoter and co-promoter who are experienced and knowledgeable about qualitative research critically assessed the focus group interview transcript. As they are from a different racial group they constantly introduced another perspective, thus putting the study into context. The study promoter and co-promoter also evaluated the entire study. Discussion of aspects of the strategies to facilitate collaboration between allopathic and traditional health practitioners was held with the Provincial Co-ordinator for the affairs of traditional healers whose Directorate will be responsible for the implementation of the strategies.

A qualitative study can be considered credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognise the description. In this study the researcher conducted member checking by continually testing her data, categories, interpretations and conclusions with the participants. During debriefing the researcher emphasised the fact that participants would be contacted telephonically should there be a need to clarify or confirm certain points stated in the interview data. Engaging in modified participant observation also assisted in increasing credibility.

The credibility of any argument is enhanced by the establishment of structural coherence, that is, the insurance that there are no unexplained inconsistencies between the data and their interpretations. Although data may conflict, credibility is increased if the interpretation can explain the apparent contradictions. Structural coherence is also influenced by the way the researcher integrates the masses of loosely connected data into a logical holistic picture in the research report. The researcher ensured that the five sets of components essential for the coherence of the study as proposed by Maxwell (1996:192) in his interactive model were fully explained. The components are: purpose of the study, conceptual context, research questions, research method and the issues of validity and reliability. The researcher also conducted a pilot interview to
determine whether the research questions and interviewing techniques provided the required information.

Applicability refers to the degree to which the findings can be applied to other contexts, settings or with other groups. It is the ability to generalise from the findings to larger populations (Krefting, 1991:216). In this study the purpose is to explore and describe the phenomenon and not to generalise. As long as sufficient descriptive data is presented to allow comparison, the problem of applicability will have been addressed. By ensuring representativeness in selecting traditional and allopathic health practitioners, and by using a qualitative design, triangulation and unstructured interviews which provided dense information about the participants, research context and setting, the researcher has addressed the issue of applicability.

Consistency refers to whether the findings would be consistent if the enquiry were replicated with the same participants or in a similar context. The researcher in this study provided the exact method of data gathering and analysis. Such dense description of methods provides information as to how repeatable the study might be or how unique the situation is. Consistency was also achieved through triangulation to ensure that the weaknesses of one method of data collection were compensated for by the use of an alternative data-gathering method. Peer examination was done to check the research plan and implementation by using an independent coder.

Neutrality is the freedom from bias in the research procedures and results. It also refers to the degree to which findings are a function of the informant and conditions of the research and not of other biases, motivations and perspectives. The criterion of neutrality is confirmability which means obtaining direct and often repeated affirmations of what the researcher has heard, seen or experienced with respect to the phenomenon being studied (Morse, 1994:105).
Confirmability includes obtaining evidence from participants about findings or interpretations of the researcher. Restating ideas or instances to those who have shared their ideas are ways to confirm ideas throughout the study. Feedback sessions or periodic confirmed informant checks are important means to establish confirmability of the data (Willis, 2007:220). Confirmability captures the traditional concept of objectivity (Krefting, 1991:217). In this study the researcher had to build in strategies for balancing bias in interpretation. This was done by requesting an independent coder to question critically the researcher’s analysis (peer review) and by keeping field notes, which can be retrieved if findings are challenged by other researchers. The researcher also obtained direct and often repeated affirmations of what she had heard or seen with respect to experiences and viewpoints of traditional and allopathic health practitioners as roleplayers in the healthcare delivery landscape in the Amathole District Municipality. Evidence was also obtained from the participants about the findings of the researcher (member checking). The strategies that were used to ensure trustworthiness are summarised in Table 2.1 below:

<table>
<thead>
<tr>
<th>Criteria to ensure trustworthiness</th>
<th>Strategy</th>
<th>Criteria</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth value</td>
<td>Credibility</td>
<td>Triangulation</td>
<td>Varied ways of gathering information through interviewing, field notes, modified participant observation and literature control.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recruitment of participants from different clinical areas for the focus group interview and use of different categories of traditional health practitioners for individual</td>
</tr>
<tr>
<td>Criteria to ensure trustworthiness</td>
<td>Strategy</td>
<td>Criteria</td>
<td>Application</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interviews. Analysis of data by the researcher and independent coders.</td>
<td></td>
</tr>
<tr>
<td>Peer examination</td>
<td></td>
<td>Use of an independent coder experienced in qualitative design and the isiXhosa language to assist with data analysis. Evaluation of the entire study by the study promoter and co-promoter. Discussion of the strategies to facilitate collaboration with the Provincial Co-ordinator for traditional healers.</td>
<td></td>
</tr>
<tr>
<td>Member checkin</td>
<td></td>
<td>Follow-up done with participants to ensure that the data gathered from interviews had been correctly interpreted.</td>
<td></td>
</tr>
<tr>
<td>Prolonged and varied field experience</td>
<td></td>
<td>Attendance at a traditional healer’s graduation ceremony, cleansing ceremony, se’ance and conference on traditional medicine</td>
<td></td>
</tr>
<tr>
<td>Criteria to ensure trustworthiness</td>
<td>Strategy</td>
<td>Criteria</td>
<td>Application</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------</td>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Structural coherence</td>
<td>Description of the purpose, conceptual context, research method and logical holistic picture in the research report</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pilot interviews conducted</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Confirmability</td>
<td>Triangulation</td>
<td>Field notes kept</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reflexivity</td>
<td>Data kept in organised retrievable form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Use of independent coder</td>
</tr>
<tr>
<td>Consistency</td>
<td>Dependability</td>
<td>Dense description</td>
<td>Complete description of the methodology used in the study, verbatim transcription of interviews, data analysis and literature control provided</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer examination</td>
<td>Use of independent coders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Triangulation</td>
<td>As already explained above</td>
</tr>
<tr>
<td>Applicability</td>
<td>Transparency</td>
<td>Dense description</td>
<td>Consistent reporting on the data that was collected in case other researchers want to conduct further studies or criticise it.</td>
</tr>
</tbody>
</table>
2.7 ETHICAL CONSIDERATIONS

Throughout the process of data collection the problem of persuading participants to co-operate with the researcher is ever present. While lack of co-operation can be disastrous in a research project, participants have a right to refuse to participate (Bless & Higson-Smith, 2006:140). It is this right that the researcher endeavoured to respect in the present study. The ethical acceptability of the study was ensured throughout the research process and attention paid to the following issues:

OBTAINING WRITTEN PERMISSION TO CONDUCT THE STUDY
Permission to conduct the study was requested from the Superintendent General of the Eastern Cape Department of Health, the District Manager of the Amathole District Municipality, the Manager of the Amahlathi Local Service Area and the Nursing Service Manager of S.S. Gida hospital (See Annexure A). Written permission was also requested from each participant (See Annexure B, Annexure C & Annexure E).

INFORMED CONSENT
Informed consent means the participant has adequate information regarding the research, is capable of comprehending the information and has the power of free choice enabling him/her to consent voluntarily to participate in the research or decline participation (Berg, 2004:65). Participants were provided with adequate written information regarding the goal of the investigation, the procedures that would be followed during the investigation and possible advantages and disadvantages to which participants may be exposed. This enabled each participant to decide voluntarily to participate. A written consent form was signed by each participant who was willing to participate in the study (See Annexure D).

FREEDOM FROM EXPLOITATION
Participants were assured that their participation or the information they might provide to the researcher would not be used against them in any way.
ANONYMITY

Anonymity means that the participant remains nameless (Berg, 2004:65). Many people are prepared to divulge information of a very private nature on condition that their name is not mentioned. To ensure anonymity, participants in this study were identified by numbers.

CONFIDENTIALITY

Confidentiality is an active attempt to remove from the research records any elements that might indicate the participant’s identity (Berg, 2004:65; Sapsford & Jupp, 2006:295). Participants were assured that information given would be used for the stated purpose of the research and not be made accessible to parties other than those involved in the research. The participant’s name would also not appear in any of the records used in this study.

PRIVACY

Participants have a right to privacy and they can decide when, where, to whom and to what extent their attitudes, beliefs and behaviour will be revealed. Anonymity and confidentiality are issues related to privacy. In this study, although a tape-recorder was used in collecting data, there was no mention of people’s names. Because the study was conducted with the aim of improving health services, participants were informed that the results would be published. Full disclosure of the findings without compromising anonymity and confidentiality would be done by the researcher. This entails describing the nature of the study, the subject’s right to refuse participation, the researcher’s responsibility and the likely risks and benefits that would be incurred. To minimise the possible risk of displeasing the participants’ ancestors for participating in the study, diviners were specifically requested to seek approval of their ancestors on behalf of the researcher.
DECEPTION OF PARTICIPANTS

The most common deception involves misleading participants about the purpose of the study. Deception violates the participant’s right to informed consent (Bless & Higson-Smith, 2006:144; Denzil & Lincoln, 2000:139). In this study the researcher did not withhold information or offer incorrect information in order to lure subjects to participate when they would otherwise have refused. In releasing the findings, the researcher will ensure that no one is deceived by the findings.

2.8 CHAPTER SUMMARY

A detailed description of the research design and methods was given in this chapter. The measures taken to adhere to ethical principles and ensure acceptability of the study were highlighted. A model to be used to evaluate the value or trustworthiness of this study was selected. Guba’s model of trustworthiness was selected and its aspect of truth value, applicability, consistency and neutrality were fully described. A description of how data was analysed using Tesch’s method was also provided. The results of the interviews, participant observation and literature control will be described in Chapter 3.
CHAPTER 3

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

The previous chapter detailed the research design and methods used. In this chapter, the findings from phase one of the study will be presented as they relate to the analysis of data obtained through individual and focus group interviews and modified participant observation. In discussing the themes and sub-themes that were identified through data analysis, the discussion will be supported by relevant quotations from the transcribed interviews. The findings will be described in a narrative format and subjected to a literature control. A literature control will therefore re-contextualise the data by providing a mechanism that demonstrates the usefulness and implications of the findings. Where no direct literature is found to support the identified themes, this will be stated.

3.2 RESEARCH FINDINGS

Data was collected from three groups of participants namely, Group 1 comprising allopathic health practitioners; Group 2 formed by traditional health practitioners and Group 3 consisting of nurses who are also traditional health practitioners. An additional group, which in essence was an extension of Group 1, was set up to make up for a deficit that was encountered in Group 1. This complementary group was formed of allopathic health practitioners from other health fields, racial groups and clinical areas as has been explained earlier in the text. The researcher subsequently named this subsidiary group, Group1a.

In Group 1 data was collected through a focus group interview, but from all other groups unstructured individual interviews were conducted. Ethical principles of research were maintained during the interviews and all participants were made aware that they could withdraw at any time if they so desired, but no-one did. The
results of the focus group interview and individual interviews will be discussed for each group as well as the themes and sub-themes that emerged. The researcher will also highlight the themes that were common to all groups.

3.2.1 FINDINGS FROM GROUP 1: ALLOPATHIC HEALTH PRACTITIONERS

Group 1 was intended to be a heterogeneous group of allopathic health practitioners; but for reasons already stated above, the group ended up being homogeneous in terms of gender, ethnicity, professional preparation and the nature of the health facility in which they worked. The researcher presented this challenge to her promoters for advice and directive. After discussing the matter, the researcher and her study promoters agreed to augment the focus group interview by conducting individual interviews with allopathic health practitioners belonging to other health fields, who met the selection criteria and had experience in other clinical areas.

Purposive sampling was used in recruiting the participants for the focus group interview as was indicated in Chapter 2. Participants gave informed consent to participate in the study by signing a consent form issued and explained by the researcher. There was also agreement to the use of a tape-recorder as the reason for and advantage thereof, were explained by the researcher. Participants in the focus group (Group 1) displayed the following characteristics:
Table 3.1: PROFILE OF GROUP 1 PARTICIPANTS FORMING THE FOCUS
GROUP INTERVIEW: ALLOPATHIC HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>GENDER</th>
<th>RACE</th>
<th>WORKING EXPERIENCE AFTER COMPLETION OF TRAINING</th>
<th>HIGHEST PROFESSIONAL QUALIFICATIONS</th>
<th>PRESENT ALLOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Black</td>
<td>15 years</td>
<td>Diploma in Psychiatric Nursing Science and Bachelor of Arts in Nursing Science (registered nurse)</td>
<td>Out-Patients Department and psychiatric clinic</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>10 years</td>
<td>Diploma in General Nursing and Diploma in Midwifery (registered nurse)</td>
<td>Maternity ward</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>17 years</td>
<td>Diploma in General Nursing and Diploma in Midwifery (registered nurse)</td>
<td>Female medical ward</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>19 years</td>
<td>Diploma in General Nursing Diploma in Midwifery Diploma in Paediatric Nursing Science (registered nurse)</td>
<td>Paediatric ward</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>41 years</td>
<td>Diploma in General Nursing and Diploma in Midwifery (registered nurse)</td>
<td>Tuberculosis (TB) ward</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>23 years</td>
<td>Diploma in General nursing and Diploma in Midwifery (registered nurse)</td>
<td>Medical and surgical ward</td>
</tr>
</tbody>
</table>

Three main themes emerged from the participants’ accounts of their experience as role-players in the healthcare delivery spectrum in the Amathole District Municipality and their viewpoints regarding the impact that the new legislation on traditional healers would have on their practice. Participants’ views regarding the mechanisms that could be instituted to facilitate collaboration between allopathic
and traditional health practitioners in order to optimise and complement healthcare delivery were also incorporated in the themes. The themes that emerged from the focus group interview are outlined below:

- Allopathic health practitioners reflected on their negative attitude towards traditional health practitioners
- Allopathic health practitioners acknowledged that they had a lack of knowledge about the new Traditional Health Practitioners Act
- Allopathic health practitioners suggested that mutual understanding was crucial to effective collaboration between traditional and allopathic health practitioners.

The themes and their sub-themes are summarised in Table 3.2 below and will afterwards be discussed.

Table 3. 2: THEMES AND SUB-THEMES FROM GROUP 1 PARTICIPANTS: ALLPATHIC HEALTH PRACTITIONERST

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Allopathic health practitioners reflected on their negative attitude towards traditional health practitioners</td>
<td>Allopathic health practitioners acknowledged that the negative attitude they held towards traditional healers emanated from the following experiences:</td>
</tr>
<tr>
<td></td>
<td>1.1 the unscientific methods used by traditional health practitioners in treating patients;</td>
</tr>
<tr>
<td></td>
<td>1.2 interference of traditional healers with the efficacy of hospital treatments and</td>
</tr>
<tr>
<td></td>
<td>1.3 delays by traditional healers in referring patients to hospital</td>
</tr>
<tr>
<td>THEMES</td>
<td>SUB- THEMES</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>2. Allopathic health practitioners acknowledged that they lacked knowledge about the new Traditional Health Practitioners Act</td>
<td>2.1 Allopathic health practitioners attributed their lack of knowledge regarding the new Traditional Health Act to non-participation in the consultation processes during the development of the Act.</td>
</tr>
</tbody>
</table>
| 3. Allopathic health practitioners suggested that mutual understanding was crucial to effective collaboration between traditional and allopathic health practitioners | 3.1 Allopathic health practitioners suggested various ways of fostering mutual understanding between allopathic and traditional health practitioners which included:  
   A. meetings;  
   B. training and development;  
   C. undertaking research and  
   D. collaboration between the relevant professional councils |

The researcher will now engage in the discussion of each theme and its related sub-themes as sequenced in the above table. To highlight a point and as a matter of emphasis, quotations derived from the transcribed focus group interview will be used. The researcher will also make reference to previous studies on the topic and to personal experience to highlight similarities or differences of experiences of the participants in the present study between those in other studies conducted in other parts of the country or world.
3.2.1.1 THEME 1: ALLOPATHIC HEALTH PRACTITIONERS REFLECTED ON THEIR NEGATIVE ATTITUDE TOWARDS TRADITIONAL HEALTH PRACTITIONERS.

Almost all allopathic health practitioners who participated in this study stated that they had a negative attitude towards traditional health practitioners. They were even warning patients against seeking the services of traditional health practitioners. This can be elicited in the following statements by different participants:

“Firstly, I think we health professionals are a barrier to working together. We do have a negative attitude and ask a person: ‘Why didn’t you come to hospital? Now, can you see how you look like? What do you want us to do now?’”

“If you remember, initially as nurses we used to have a negative attitude towards traditional healers, like, I think somebody mentioned this earlier; for example a mother has gone to somebody with her baby and had an enema, then you would quarrel with that mother.”

“I think the Act will assist me in that the attitude I always had against traditional healers, I’ll change my attitude towards traditional healers.”

“Sometimes a nurse on training will be said to have ‘amafufunyana’, the traditional healer says so and the ‘amafufunyana’ turn out to be a pregnancy. My grandmother became deaf after being treated by the sangomas long before I became a nurse, so I became negative to everything associated with sangomas.”

“We have a tendency of looking down upon them as health professionals.”

“Really health professionals used to undermine these traditional healers and undermine their practice.”
There was, however, a lone voice of a participant whose working experience was mainly in the psychiatric services. She seemed to have experienced a slightly different working relationship with traditional health practitioners and her remark was:

“Because I am a Xhosa person, sometimes I do come across patients and e-e-r I do also suggest because I grew up in rural areas and we have been following traditional healing. I do say ‘Why don’t you go and see the traditional healer for this condition?’ For instance if a child has been sent to the psychiatric department suffering from what we call enuresis that is ‘ukuzichamela’ I do suggest, ‘Why don’t you go and do something traditional, cultural because this child might be needing a traditional ritual that we call ‘imbeleko.’ And sometimes when somebody is mentally disturbed and you sit down and try to interview the family and interview the patient and you can’t find anything that is possible for causing the patient to come. At the back of my mind I do think about something and talk to the family like this: ‘Did you try something?’ …..because I grew up in these communities.”

Allopathic health practitioners expressed the view that the negative attitude they displayed might be one of the reasons that caused patients to be dishonest and hide the fact that they had consulted a traditional healer before presenting themselves at the hospital or clinic. This negative attitude of hospital nursing staff in handling patients who admitted to having consulted a traditional healer was also pointed out by Troskie (1997b:39) as resulting in patients not mentioning that fact.

The researcher noted that the negative attitude of allopathic health practitioners was not held against every type of traditional health practitioner. This assertion was made after establishing that before the publication of the Traditional Health Practitioners Act, Act No. 35 of 2004 by the South African Government, in the Province of the Eastern Cape an Act titled “Application of Health Standards in
Traditional Circumcision Act”, Act No.6 of 2001 already existed. This Act formalised and reinforced harmonious working relationships between traditional surgeons (iingcibi), traditional nurses (amakhankatha), medical doctors and nurses. The Act was passed by the Eastern Cape Provincial Government to curb morbidity and mortality resulting from mismanagement of the circumcision rite by unscrupulous traditional surgeons. The responsibilities of traditional surgeons, traditional nurses and allopathic health practitioners in relation to the circumcision rite are well stipulated in this Act and these role-players are already collaborating and co-operating as a team to oversee the implementation of health standards in the circumcision rite. Except for this formal, harmonious relationship between traditional surgeons and allopathic health practitioners, no similar relationships existed between allopathic health practitioners and other types of traditional healers.

Participants highlighted the fact that the negative attitude they had developed as allopathic health practitioners emanated from some of the practices of traditional health practitioners. These problems which are presented as sub-themes were the perceived problematic unscientific methods used by traditional health practitioners in treating patients, interference of traditional healers with the efficacy of hospital treatments and delay by traditional healers in referring patients to the hospital. Their discussion now follows:

**SUB-THEME: ALLOPATHIC HEALTH PRACTITIONERS ACKNOWLEDGED THAT THE NEGATIVE ATTITUDE THEY HELD TOWARDS TRADITIONAL HEALERS EMANATED FROM THE FOLLOWING EXPERIENCES.**

1.1 The unscientific method used by the traditional health practitioners in treating patients
Participants expressed concern regarding unscientific methods used by the traditional health practitioners when treating patients. These included not maintaining sterility through hand-washing before and after attending to patients,
not using sterile equipment nor measuring the strength of medication given to patients, not prescribing the dosages of their traditional medicine according to the age and weight of the patient and also prescribing the medicines for an indefinite period. There was also no proper storage of their traditional medicines. This concern was cited by one participant as follows:

“The reason why we discourage them from seeing traditional healers is because those medicines of traditional healers are not sterile and they do not wash the hands.”

Other participants added:

“Yes…they are given strong medicines, not measured, causing them to be worse, so we are experiencing that complication.”

“…and the person is taking the treatment for an indefinite time and that is dangerous to the client because sometimes it is damaging internal parts of the client.”

“One thing that I found quite interesting and that I never could understand was the fact that people with hypertension and cardiac failure specifically used to go to these traditional healers and would come back with cuts in their legs and the explanation was that these incisions were made to get rid of the “amafufunyane.”

All participants shared what they had experienced as registered nurses working in the various clinical settings regarding their encounters with patients presenting with complications after consulting traditional health practitioners. The complications included amongst others, distended abdomen, diarrhoea, dehydration, damaged internal organs, poisoning and sores around the feet, arms and ribs. The latter were the result of chains used by the traditional health practitioners to restrain mentally disturbed patients. The general concern reported by allopathic health practitioners was the negative impact that the unscientific methods used by traditional health practitioners had on the practice
of allopathic health practitioners. This concern was expressed by one of the participants as follows:

“Coming from a different cultural background, traditional healing to me was something that was unacceptable because from what I viewed was seeing all these patients coming to us after being there and coming to us in a very bad state.”

Similar concerns were expressed by participants in a number of studies undertaken by various researchers. For instance, in a study conducted by Peu (2000:140) on the attitude of community health workers towards integration of traditional health practitioners in primary healthcare in the North West Province, community health nurses raised concern about the traditional healers’ unhygienic practice and felt that this was a constraint that could hinder integration of allopathic and traditional healing systems. The issue of unhygienic conditions under which traditional health practitioners operated and the misdiagnoses that they provided at times, were also highlighted as disadvantages of the traditional healing system by Mafalo (in Melato, 2000:32). Summerton (2006:21) also expressed concern about traditional healers who exacerbated dehydration in already emaciated patients by using enemas and inducing vomiting. Similarly, in a study conducted by Hopa (1996:79) on the perceptions on integration of traditional and western healing in contemporary South Africa, the medical doctors spoke out strongly about the fatal therapeutic practices by traditional healers who would, for instance, administer herbal enemas to babies. The imprecise diagnoses often given by traditional healers coupled with the use of potions that were neither standardised nor dispensed to patients in specified doses or strictly regulated quantities was also pointed out by Dheyongera (1994:15) as a shortcoming of traditional medicine. Hillenbrand (2006:1) shares a similar situation that exists in Cameroons where advocates of conventional medicine argue that traditional medicine is fraught with problems of imprecise dosage, poor diagnosis, exaggerated claims of abilities and inadequate knowledge of anatomy,
hygiene and disease transmission, all of which put their patients’ health and lives at risk.

1.2 **Interference of traditional health practitioners with the efficacy of hospital treatments**

Participants stated that in some cases traditional health practitioners and the patient’s relatives interfered with the efficacy of hospital treatments by sneaking a bottle of traditional medicine from home to give to a patient admitted in hospital. The tendency was to give an overdose of the traditional medicine in an attempt to make up for the times that the healer would not be present to give subsequent doses. The effectiveness of the hospital medicines was thus compromised which would result in a sudden change in the patient’s condition probably caused by drug interaction. In some cases it would result in the death of the patient, leaving nurses, doctors and relatives baffled. Both the traditional health practitioner and the relatives do not usually realise that their actions could have created the problem. Instead they would suspect that the allopathic health practitioners might have prescribed medication to the patient resulting in a change in his/her condition. One participant illustrated this matter:

“The relative will come and give the medicine, like for instance, the whole mug of it, just because she will not be able to come the other times, like at night. While the hospital treatment was about to be effective, the condition suddenly changes and we won’t know that there is another type of medicine that is being given secretly.”

The discovery of a bottle with a brownish red or blackish medicine in the patient’s locker is usually a useful pointer that a traditional medicine is being secretly taken. This suspicion was confirmed in the current study by the utterances of one of the Group 2 participants, when individual interviews were conducted. This participant, a herbalist, indicated that he sometimes visited his patients in hospital
and brought them traditional medicines in a cool-drink bottle to disguise. An excerpt from the participant’s account of such an incident:

“I steal other people in hospital. I pour medicine in a cooldrink bottle. I give him/her to drink and the following day he/she recovers and is discharged.”

By “stealing” the participant was not literally meaning taking away the patient secretly. This is a Xhosa idiomatic expression to indicate that something is done secretly. Coupled with the problem of a possible drug interaction resulting in deterioration or death of a patient, was the interference said to be caused by traditional health practitioners who were also nurses. This cadre of health practitioner was accused by the participants of interfering with the general management of patients admitted to hospital or those about to be admitted or being prepared for surgery. Expressing this concern the participant said:

“We sometimes work with western trained people who are traditional healers. We experience problems with them because they mix two things; the traditional healer and health practitioner. They are encouraging people to go to traditional healers if somebody stays in hospital for some time and does not heal the one I was working with often stated to the patient “if you can go to a traditional healer you can be better.”

The nurse who was also a traditional health practitioner would secretly advise the patient that his/her illness would never be cured by western methods but through undergoing a cultural ritual. Doctors and nurses would suddenly be faced with a patient who refused hospital treatment and instead demanded to be discharged. In some cases the same patient would return to hospital in a more serious condition than before. This was confirmed by statements made by Group 3 participants, that is nurses who were also traditional healers as contained in the following statements:
“You are shown this thing. ‘They (ancestors) say this patient is just sleeping here: if he/she would do this and that he/she would be alright.’ If I am familiar with the patient I secretly tell him/her.”

“I whisper to him/her and say leave this and go to a particular place. I am saying this secretly.”

This disruption in the management of patients caused allopathic health practitioners to have a negative attitude towards traditional healers.

In a study conducted by Peu (2000:95) on the attitude of community health nurses towards integration of traditional healers in primary health care in the North West Province, participants, specifically traditional healers mentioned that they were also concerned that mixing traditional and western medicine could delay or nullify the healing process and cause complications and warned their patients about it.

1.3 Delays by traditional healers in referring patients to the hospital

Allopathic health practitioners were concerned that traditional health practitioners were keeping patients under their care for too long and only advised patients to attend a clinic, hospital, or private doctor when the disease was at an advanced stage. Expressing this concern one participant stated:

“And she would state that the child had been ill for two to three weeks and that if you asked why she was only bringing the child now she would say ‘as Xhosas we had jumped this way and that way.’”

This was creating problems for allopathic health practitioners as it resulted in prolonged hospitalisation and made it difficult to institute certain diagnostic, surgical and medical procedures. Allopathic health practitioners alleged that the reluctance among traditional health practitioners to refer patients even if they
noted that the patient was not improving was caused by greed and jealousy. This was cited by one participant:

“… jealousy or greed crept in and they tended to make themselves things that they were not. What makes them not to refer is money.”

Summerton (2006:21) also highlighted this tendency of traditional health practitioners to refer the patients to a western health facility as a last resort when the patient was in the final stages of illness with minimal chances of successful treatment interventions. Commenting on the delay in referring the patients timeously, Troskie (1997b:34) argued that some healers were afraid to refer their patients fearing that they might be interpreted as incompetent.

Information obtained from one of the traditional birth attendants when individual interviews were conducted by the researcher, substantiated the reason for the delay in referring a patient to allopathic health practitioner. The participant mentioned that in cases of prolonged labour especially with an unmarried primigravida or newly-wed woman, they would report the matter to the head of the household who would go to the cattle kraal to appeal for help from his ancestors. He would indicate to the ancestors that he was not angry about the pregnancy and would plead with them to relieve the woman in labour. One participant narrated this situation as follows:

“We would inform the father of the household that the daughter-in-law does not deliver the baby. There is a delay. He would talk aloud outside the cattle kraal saying to his ancestors ‘So & So has been in labour for quite some time, we don’t know what is holding her. She must be relieved’. If it was his daughter he would say ‘No, I am not angry Mathile (clan), this child must be relieved’.” If this failed, a man or woman known to possess a traditional medicine that induces labour, would be approached. Should both attempts fail, then we send the patient to the doctor.”
The delay in referring the patient timeously to hospitals, clinics and private doctors, coupled with interference of traditional health practitioners with the efficacy of hospital treatment as well as application of unscientific methods when treating patients were all issues cited as root causes of the negative attitude of allopathic health practitioners towards traditional healers.

3.2.1.2 THEME 2: ALLOPATHIC HEALTH PRACTITIONERS ACKNOWLEDGED THAT THEY LACKED KNOWLEDGE ABOUT THE NEW TRADITIONAL HEALTH PRACTITIONERS ACT.

During briefing and debriefing, allopathic health practitioners stated that they lacked knowledge about the new Traditional Health Practitioners Act, Act 35 of 2004. This knowledge deficit was further demonstrated by their inability to deliberate comprehensively on the impact that the Act would have on their practice. Some participants requested the researcher to furnish them with copies of the Act stating that they had neither seen it nor participated in the processes of its development but two participants from Group 1a indicated that they had seen the Act but had not interrogated its contents:

“I have seen the Act but I have not read it.”

The researcher then identified the issue of non-participation of allopathic health practitioners in the consultation processes during the development of the Act as a sub-theme of this theme.

SUB-THEME: ALLOPATHIC HEALTH PRACTITIONERS ATTRIBUTED THEIR LACK OF KNOWLEDGE REGARDING THE NEW TRADITION HEALTH PRACTITIONERS ACT TO NON-PARTICIPATION IN THE CONSULTATION PROCESSES DURING THE DEVELOPMENT OF THE ACT.

During the focus group interview, participants stated that they had not taken part in any of the processes of the development of the Act, namely, attending public
hearings and workshops on the Act, or getting an opportunity to comment on a draft form of the Act. Their initial awareness about the existence of such an Act was from the occasional discussions that they had listened to over the radio and on television, otherwise as a policy document they had not seen the Act. They commented that they could not articulate what the impact of the Act would be on their practice as allopathic health practitioners.

“To be honest, I have no idea what effect this Act will have on me as a professional. I don’t know what it talks about. I sometimes listen to that programme in the radio, is it on Saturdays by the way when N…makes those talks about traditional healing?”

Another one added:
“these days we don’t see these things. They used to ask us to comment on Green and White Papers and drafts. Maybe, it’s because I was working in the community then.”

In 1997, the South African Government conducted Provincial Public Hearings on the Act with the aim of bringing all interested parties together to get their perspectives on how the traditional health practices should be regulated. The focus was on getting input on issues such as the establishment of a statutory council for the traditional healers, issuing of medical certificates to patients by the traditional healers and medical coverage of the services provided by the traditional healers (Mathieson, 1997:2). During briefing and debriefing, the participants in the current study stated that they were not even aware of such processes. This lack of knowledge about the contents of the Act, lengthened the duration of the briefing session. The researcher first had to highlight certain pertinent issues, especially relating to the purpose of the Act, the establishment of the Interim Traditional Health Practitioners Council of South Africa, registration, training and practice of traditional health practitioners as well as the protection of the public. Understanding these facts was crucial to stimulate the discussion of
the impact that the new legislation on traditional healers would have on the practice of allopathic health practitioners and on mechanisms that could be instituted to facilitate the development of a strategy to promote collaboration between allopathic and traditional health practitioners in pursuance of what was advocated in Chapter 2, Section 6(2) (a) of the Traditional Health Practitioners Act, Act 35 of 2004.

The reality of inadequate consultation processes on the Traditional Health Practitioners Act surfaced after the researcher had completed the focus group and individual interviews of all groups. It was publicised in the media that this Act was being held in abeyance as it was being challenged through the Constitutional Court by a certain group of stakeholders called "Doctors for Life" for its shortcomings, especially relating to the process followed in its development with special reference to consultation of stakeholders. Consequently, the Constitutional Court ruled out that the Act be held in abeyance and all parliamentary consultation processes and procedures be followed before its reintroduction in February 2008. This scenario will be elaborated in chapter 4.

3.2.1.3 THEME 3: ALLOPATHIC HEALTH PRACTITIONERS SUGGESTED THAT MUTUAL UNDERSTANDING WAS CRUCIAL TO THE EFFECTIVE COLLABORATION BETWEEN TRADITIONAL AND ALLOPATHIC HEALTH PRACTITIONERS.

Mutual understanding between allopathic and traditional health practitioners was viewed by allopathic health practitioners as central and crucial to effective collaboration. As one participant commented:

“If we want collaboration, each has to understand the other side. Each group needs to understand what the other is capable of doing and limitations of each.”
Participants stated that they handled patients who had first consulted traditional health practitioners but did not know which traditional healer and which traditional medicines had been given or what procedures had been performed on the patient.

“We are dealing here with a faceless healer. We are not sure about the way they are trained, the way they are working, the way they are doing things.”

One participant pointed out that the traditional health practitioner’s side was dominated by illiteracy with a tendency to resist change and in most cases the resistance was caused by not understanding issues. He noted this as follows:

“ …… the level of understanding differs, that is for sure, the reason being that mostly, that side of traditional healers is dominated for the greater part by illiteracy, inability to interpret changes in the proper way. Right? And this then causes resistance.”

To increase the acceptance of traditional health practitioners and better understanding of their capabilities by the allopathic health practitioners, one participant suggested that demonstrations be done by diviners on patients to appraise their western-trained counterparts about their skills in the aspects of diagnosing and treating patients. The diviner would have to diagnose the patient and see if he identified the same problem in a patient as was seen by the western-trained health practitioner. This would at least make the western-trained practitioners aware of the unique skill, knowledge and powers of the traditional health practitioners. Alternatively, a traditional health practitioner could be assigned a patient suffering from a particular medical condition that the traditional healer claimed to be capable of curing. A follow-up could be made on that patient to observe the treatment outcomes.
“So, if we can sit down, listen to their claims of being able to treat a condition, we can allow them to take a patient, see what has been done, see the results.”

Should the patient improve or recover the traditional medicines that were used to cure that patient should be tested in laboratories to confirm their effective elements. In that way it could be generally understood that indeed a particular disease could be successfully cured by a traditional healer using a particular type of traditional medicine.

Peu (2000:140) concedes that a lack of appropriate knowledge and understanding about each other’s profession is a constraint that can hinder integration of traditional healers in primary healthcare. This viewpoint is also upheld by Ojanuga (1981:410) who has remarked that one of the reasons causing medical and traditional doctors to anticipate problems in working together is the fact that they have had few interactions on a professional level and as a result know little about each other. Ncayiyana (in Kale,1995:1158) sums this up by advising allopathic health practitioners to know what training traditional health practitioners have undergone, how they actually certify themselves and only then can it be established whether traditional healers are an asset or a liability to South Africa’s healthcare system.

Subsequent to the argument for a need for mutual understanding between allopathic and traditional health practitioners, participants suggested various mechanisms for fostering understanding and a spirit of working together between allopathic and traditional health practitioners. These mechanisms were then identified as sub-themes of Theme 3 and their discussion now follows.
SUB-THEME: ALLOPATHIC HEALTH PRACTITIONERS SUGGESTED VARIOUS WAYS OF FOSTERING MUTUAL UNDERSTANDING BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS.

A. Meetings

Participants suggested that they needed to hold meetings with traditional health practitioners to address common health-related issues. The suggestion of one participant was that such meetings be held at a central point like a community hall where problems emanating from the practice of one group that adversely affected the other group would be pinpointed. Elaboration of each group’s working methods would also be addressed. As one participant pointed out:

“What I am suggesting, the best strategy to work together between the western people and the traditional healers is to continue having meetings. I am saying let us talk to them, let us try and understand one another. Let us invite them to work together, let’s have a meeting maybe in a community hall where we can have questions, hearing from this person and that person and then we answer.”

The idea of a meeting was alluded to by other participants

“Meetings will be a way of understanding between us, what the others are doing and what the other side is doing, so that we can plan together.”

“When we talk together what I am saying we can come up with an understanding of one another. Conducting meetings where common problems will be addressed; they may for instance, come up and say ‘we have got a problem with you western people, with one, two and three. Why are you doing this?’”

Awareness campaigns were suggested as complementary to the meetings. These would be information-sharing campaigns to educate traditional health practitioners about cleanliness and transmission of diseases as well as illnesses.
that they could attend to and those that they had to refer to allopathic health practitioners.

“When we have these awareness campaigns, educate them about the transmission of diseases and cleanliness.”

“I am supporting the speaker who said there must be awareness campaigns as it is where we will tell them that we won’t be able to send patients to them, maybe they will understand when we speak to them.”

In her study on the willingness of traditional healers regarding collaboration with western psychiatric healthcare workers, Mototo (1999:102) also recommends that there should be contact between traditional healers and western psychiatric healthcare workers through meetings to share ideas on health-related issues.

**B. Training and development**

Participants stated that training the traditional healers was expected to assist them in understanding health issues and the health system. They felt that traditional health practitioners, especially traditional surgeons and traditional birth attendants, needed to have their skills sharpened to enable them to perform circumcision and conduct deliveries efficiently without causing sepsis or death of the clients. This was highlighted by one participant:

“I think they need to have their different skills sharpened, like a traditional surgeon be trained to do circumcision perfectly, a traditional birth attendant be trained to do delivery thoroughly”

The content of the training recommended by allopathic health practitioners related to the provisions of the Traditional Health Practitioners Act itself and to elementary information on disease conditions and the use of correct strengths as well as measurements of medicines, safe storage of medicines, maintenance of
sterility when handling the herbs and scheduling the duration of the use of a traditional medicine.

The following excerpts reflect the training content recommended by the participants:

“We won’t be able to sharpen the skills of the diviners and herbalists as they practise at another level under the directive of the ancestors; but they can be taught things like measurements in the medicines that they use, time schedules like if I give you this bottle of medicine, it must last for two weeks like in hospital. Their medication must also be stored properly.”

“Getting them involved in issues like health promotion where we could look at having a training course for traditional healers training them on basic diagnostic skills to enlighten them with regard to signs and symptoms of common illnesses such as diabetes, hypertension, TB, HIV and AIDS so that they also will be able to refer appropriately to health practitioners.”

“If we could have a formalized standardized course where we could actually issue them with certificates that say they have undergone a basic course.”

“There need to be workshops attended by both professionals and traditional healers where traditional healers will be informed about the diseases and how to avoid transmitting them from other clients and to themselves. They also need training about the Act itself.”

A medical centre was suggested to offer such training where identified allopathic health practitioners from the hospital would give lectures and monitor the training to ensure that traditional health practitioners had basic understanding about medical issues.
“To promote liaison between traditional healers and western trained nurses and doctors, there needs to be a medical center where all types of traditional healers: traditional birth attendants, traditional surgeons and diviners practice, so that we can have identified members from the hospitals to monitor there so that those healers get used to medical issues.”

Likewise, participants felt that allopathic health practitioners needed to acquire basic understanding of the traditional healing systems. Participants suggested inclusion of culture and traditional healing in the nurses’ curriculum. This is captured by the following statements:

“My view is that the Act should be something that is taught within our western medicine and nursing schools to create an understanding within all our practitioners and future practitioners.”

“It is good that we are now going to discuss as health professionals cultural related conditions and cultural related treatments. We can introduce these studies to the students so that they are aware of these things.”

One participant suggested that open days be held in hospitals specifically for traditional health practitioners to expose them to certain investigative procedures like using a bauwmanometer to check blood pressure and X-rays to confirm existence of a fracture or Tuberculosis.

Upvall (in Peu, 2000:137) stresses the importance of training traditional healers so that they will know when to refer patients to health services and when and how to prescribe medicines. Findings in Peu’s study (2000:109 & 126) also revealed that 97.8% of the participants felt that traditional healers should undergo some form of recognised training and 32.7% felt that the training should be in basic health matters and evaluated on completion. Although a number of researchers (Molepo, 2000:61-62 & Melato, 2000:79 ) do support the notion of
training the traditional healers, they differ on the duration and course content of such training. Mototo (1999:104) further suggested that the nurse as a key person in co-ordinating all aspects of care in the community should be willing to take this responsibility of training traditional healers.

In a workshop on African Traditional Medicine that was attended by the researcher in Gauteng Province in June 2006, the issue of education and training of traditional healers was discussed at length by the delegates. It was suggested among other things, that traditional healers needed to be trained in record keeping and entrepreneurial or business development skills to ensure self-sufficiency and self-reliance. The need to explore the meaning of concepts used in the training of traditional healers, like the concept of “ukuthwasa”, was brought up as well as the issue of accrediting training institutions for traditional medicine. It was further felt that an audit of existing programmes for the training of traditional healers in universities, health departments and non-governmental organisations be conducted and the relevance of these programmes be evaluated. The idea of training traditional healers on business development skills can be viewed as far-fetched; but when this issue was raised in that conference, the researcher was reminded of the poor living conditions that she had observed among the participants when she was conducting individual interviews with traditional healers. Poor living conditions prevailed especially among the poorly educated diviners and herbalists despite being patronized, judging by the attendance for consultation by clients on the day of the individual interviews as well as from their popularity as healers among their communities and the entire province.

C. Undertaking research

Participants felt that there was a need to undertake research. They argued that understanding what traditional healers were capable of doing was difficult because no research has ever been conducted nor records and statistics kept of patients who had been successfully treated by the traditional health practitioners.
In order to understand the capabilities of traditional health practitioners, there was a need to conduct studies to substantiate claims made by traditional health practitioners of being able to cure certain conditions. A follow-up of patients attended to by traditional health practitioners to establish what was done and the outcomes thereof would give an idea about the traditional healers’ expertise and knowledge. As one participant articulated:

“Unfortunately because we have not done research, we have no statistics, no record. You see the problem with Xhosas, I am a Xhosa, is that there are no studies that have been conducted in connection with the cultural rituals and beliefs”

As a starting point of establishing understanding through research, the participant suggested that testimonies be obtained from people who claimed to have been successfully cured of their illnesses by the traditional health practitioners.

“There is no written record, so the best record we have in the communities are the people who had been helped by the traditional healers. People should come up with their stories that I was suffering from this and that and I was cured by this, we start recording them.”

To support her viewpoint further, the participant quoted a lady in her village who had for years helped a number of women to conceive after failed endeavours by allopathic health practitioners in hospitals and infertility clinics.

“I know of a woman back at home when I was growing up when doctors had given up and said a person would never have children; but that woman would do what is called ‘ukumisela’ (make a person conceive), so these are the things. We could start counting how many people consulted that lady, the people doctors had given up saying they would never have babies.”
A database should also be created of people who had been harmed or killed by a traditional medicine. This point was raised by another participant:

“I think there is still a lot to be done. If for instance we could take statistics and find out how many people have been harmed by the Xhosa medicines that are said not to have been tested.”

The viewpoint pertaining to the issue of research was raised by participants in Ojanuga’s study (1981:408) in which eighty eight percent (88%) of the medical doctors suggested joint ventures between the traditional healers and medical doctors in conducting research. The issue of research was also raised in the workshop on traditional medicine that was held at Kopanong Conference Centre in Gauteng in June 2006. In that conference, the Commission on research and development recommended that there should be capacity building of traditional healers in the area of research by making them part of the research teams of the Medical Research Council conducting research on their medicinal plants. It was also pointed out that there was a need for formal co-ordination of research on African traditional medicine.

D. Collaboration between the relevant professional councils
Participants expressed concern that whilst the Traditional Health Practitioners Act was advocating promotion of liaison between traditional and allopathic health professional, the registering and standards-generating councils that control the practice of allopathic health practitioners might be prohibitive especially when it came to referral of patients by allopathic health practitioners to traditional healers. This point was also raised by one participant in Group 3 who is both a nurse and a traditional health practitioner.

“What has to agree is that place that controls them: it’s their council and that of traditional health practitioners that have to agree. Without them uniting, doctors will not move forward. It has to be the council that agrees that it is accepting that
there can be referrals. This has to be discussed at council level so that the council can inform its doctors.”

Participants advised that medical and nursing councils needed to be transformed in order to accommodate the traditional healing system. This was pointed out by one participant:

“The councils should start now to open their eyes, try to understand and try to change. I mean they must get good understanding of traditional healers because we do believe that people do go to traditional healers.”

This concern is also expressed by Kirsch (in Kale, 1995:1185) when he states that the problem lies with the Medical and Dental Council (currently called the Health Professionals Council) which has a rule that precludes him as a doctor from working with a traditional healer.

### 3.2.2 FINDINGS FROM GROUP 1 a: ALLOPATHIC HEALTH PRACTITIONERS BELONGING TO OTHER HEALTH FIELDS

After noting that the focus group interview with sample Group 1 had eventually ended up comprising a homogeneous group of black, female registered nurses only, the researcher decided to include another group of participants, Group 1a to make up for the fields of study of allopathic health practitioners that were not represented in the focus group interview. The initial arrangement as outlined earlier on, was to include a pharmacist, medical officer and nurses in the focus group interview that were not represented, but because of logistical realities that emerged because of a shortage of medical officers and pharmacists, participants from these categories were not available to participate. On being confronted with this situation, the researcher presented the matter to her study promoters for advice and decisive action. It was then agreed by the researcher and her promoters that individual interviews be conducted with allopathic health
practitioners belonging to other health fields who met the selection criteria. This predicament was discussed in the previous chapter. The profile of the four participants that were eventually interviewed to address the deficit is summarised below:

**Table 3.3: PROFILE OF GROUP 1a PARTICIPANTS**

<table>
<thead>
<tr>
<th>GENDER</th>
<th>RACE</th>
<th>YEARS OF EXPERIENCE AFTER QUALIFYING</th>
<th>HIGHEST PROFESSIONAL QUALIFICATIONS</th>
<th>FIELD /AREA OF SPECIALIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>White</td>
<td>34 years</td>
<td>Bachelor of Pharmacy</td>
<td>Worked in a retail pharmacy and thereafter in a hospital pharmacy. The participant is currently responsible for conducting inspections of hospital and retail pharmacies and herbal shops</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>25 years</td>
<td>Masters in Public Health</td>
<td>Worked in a clinic as a registered nurse, a nurse tutor and in the district health services</td>
</tr>
<tr>
<td>Female</td>
<td>Coloured</td>
<td>13 years</td>
<td>Bachelor of Nursing Science (Education &amp; Administration)</td>
<td>Worked as a registered nurse in the Trauma Unit, and in a psychiatric hospital</td>
</tr>
<tr>
<td>Male</td>
<td>White</td>
<td>15 years</td>
<td>Bachelor of Medicine and Surgery plus Masters in Business Administration</td>
<td>The participant worked in a district and regional hospital as a medical doctor</td>
</tr>
</tbody>
</table>

The following themes and sub-themes emerged from the interview results of the participants who were allopathic health practitioners selected to complement a
potential deficit in the representation of professional groupings of participants for the focus group interview:

- Participants stated that they had no direct interaction with traditional health practitioners and
- Participants highlighted understanding between traditional and allopathic health practitioners as a prerequisite to collaboration between them.

Given the overlap with the findings emanating from the focus group interview, the findings from individual interviews from this group were integrated into those of Group 1.

3.2.3 FINDINGS FROM GROUP 2: TRADITIONAL HEALTH PRACTITIONERS

Individual interviews were conducted with 14 traditional health practitioners at their homes; but only one was held in the participant’s place of employment. All the participants were above 50 years of age, consisting of four diviners, four herbalists, three traditional surgeons and three birth attendants. There were ten males and four females excluding the female diviner with whom a pilot study was conducted. The level of education of the participants ranged from being illiterate to possession of a doctoral degree in philosophy. Participants were recruited from different local municipalities falling under the Amathole District Municipality, namely, Nkonkobe, Mhlontlo, Mbhashe and Buffalo City. They were from a variety of residential settings: rural, urban and informal resettlement areas. Representivity of the group in terms of category of healer, gender, educational status and geographical area was thus ensured as is summarised in the profile of the participants in Table 3.3 below.
Table 3.4: PROFILE OF GROUP 2 PARTICIPANTS: TRADITIONAL HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NUMBER</th>
<th>GENDER</th>
<th>LEVEL OF EDUCATION</th>
<th>RESIDENTIAL AREA</th>
<th>PROFESSIONAL PREPARATION</th>
</tr>
</thead>
</table>
| Diviners                  | 4      | 1 +1 Pilot study | 3 Iliterate to possession of a Doctoral Degree | 1 Urban: Buffalo City  
2 Rural: Mbashe & Mhlontlo local Municipalities  
2 Township: Buffalo City | All participants had undergone the thwasa process. Acquisition of knowledge and skills is through ancestors and mentorship or guidance from a fully-fledged traditional healer. There is a history of another family member who was either a herbalist or diviner. |
| Herbalists/ traditional doctors | 4      | Nil             | 4 Iliterate to the level of Grade 8            | All from the rural areas:  
1: Nkonkobe Local municipality  
3: Buffalo City municipality | Skill learnt from a family member or relative who is or was a herbalist, from other herbalists as well as augmented through reading pamphlets, magazines or newspapers that advertise names and uses of traditional medicines |
<p>| Traditional surgeons      | 3      | Nil             | 3 Iliterate to Bachelor of Arts Degree         | 2 Rural and 1 township                                                         | The participants were never taught the skill but performed the |</p>
<table>
<thead>
<tr>
<th>TYPE</th>
<th>NUMBER</th>
<th>GENDER</th>
<th>LEVEL OF EDUCATION</th>
<th>RESIDENTIAL AREA</th>
<th>PROFESSIONAL PREPARATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Birth Attendants</td>
<td>3</td>
<td>Female</td>
<td>Nil</td>
<td>1 Township</td>
<td>The participants learnt the skill from either their own mothers, mothers-in-law or other elderly women in the community</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Males</td>
<td>Illiterate to Grade 6</td>
<td>2 Rural or resettlement area. All from Buffalo city</td>
<td>operation on request by the prospective initiates on the basis of having undergone the circumcision rite themselves as expected of Xhosa men. Also acquired the skill through instruction by the ancestors or another practising traditional surgeon. The participants were all males as expected in the Xhosa culture.</td>
</tr>
</tbody>
</table>
The interviews which were conducted in Xhosa lasted between 45 minutes and 2 hours with interruptions in most cases as was mentioned earlier in Chapter 2. The four themes that emerged from the individual interviews held with the participants in this group were that:

- traditional health practitioners experienced a relationship with allopathic health practitioners that was characterised by a one-sided referral system;
- the new Traditional Health Practitioners Act was perceived by most traditional healers as having both beneficial and threatening elements related to their practice; and
- traditional health practitioners suggested possible areas of collaboration with allopathic health practitioners

The themes and their sub-themes are depicted in Table 3.4 below.

Table 3. 5: THE IDENTIFIED THEMES AND SUB-THEMES RELATING TO GROUP 2: TRADITIONAL HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Traditional health practitioners experienced a relationship with</td>
<td>-</td>
</tr>
<tr>
<td>allopathic health practitioners that was characterised by a one-sided referral system.</td>
<td>2.1 Perceived beneficial elements of the Act were:</td>
</tr>
<tr>
<td></td>
<td>A. elimination of unscrupulous practitioners;</td>
</tr>
<tr>
<td></td>
<td>B. economic benefits for traditional health practitioners and</td>
</tr>
<tr>
<td></td>
<td>C. occupational protection of the traditional healers</td>
</tr>
</tbody>
</table>
The researcher will now embark on the discussion of each theme and sub-theme. Such discussion will relate to the experiences of the traditional health practitioners as role-players in the healthcare delivery continuum in the Amathole District Municipality prior to the legalisation of traditional healers as well as to their viewpoints regarding the impact that the new legislation on traditional health practitioners will have on their practices. The themes will also reflect the mechanisms that should be instituted to promote collaboration between traditional and allopathic health practitioners from the perspectives of traditional health practitioners.

3.2.3.1 THEME 1: TRADITIONAL HEALTH PRACTITIONERS EXPERIENCED A RELATIONSHIP WITH ALLOPATHIC HEALTH PRACTITIONERS THAT WAS CHARACTERISED BY A ONE-SIDED REFERRAL SYSTEM.

Commenting on their experience as stakeholders in health service delivery in the Amathole District Municipality, participants stated that their working relationship with allopathic health practitioners before publication of the Traditional Health Practitioners Act, had been characterised by a one-sided referral system, with
traditional health practitioners referring patients to allopathic health practitioners and the latter not acting likewise. As one participant bitterly complained:

“If only they can stop depriving us of patients. You know? Doctors eat everything. They keep a person saying to him/her ‘come, come again, come again for injection, or come again to fetch your treatment.’ The doctor could give the patient a letter that says ‘go to a black doctor’ even if he does not state the name of that doctor. They don’t send them. This must not be one-sided.”

This viewpoint was supported by another participant as she said:

“We need to treat ourselves as partners; you see… the very referral system is a one-way traffic.”

Almost all participants regarded reciprocal referral of patients as a crucial factor and the essence of the concept of working together.

“The doctor in turn must refer to a traditional healer. That is the right way of working together…..there lies co-operation.”

Most participants viewed the one-sided referral system as stemming from the negative attitude of allopathic health practitioners who looked disparagingly upon traditional healing and so they refrained from referring patients to traditional healers. Doctors were described as aloof and not prepared to admit when they were unable to arrive at a diagnosis or to heal the patient. They would refer the patient from one specialist to another with no improvement. The patient would ultimately consult a traditional healer when the disease was at an advanced stage. One participant remarked about this situation:

“..The problem is that the allopathic health practitioners do not want to say they can’t find the diagnosis. They keep a patient until he dies without having a diagnosis.”
“They are still looking disparagingly on issues pertaining to traditional healing.”

A similar viewpoint was expressed by another participant:

“ It’s an attitude that developed from racism, that anything African is paganised and below standards, and anything African is dangerous.”

Traditional surgeons were the only type of traditional health practitioner that seemed to be enjoying recognition by allopathic health practitioners in terms of cross-referral of patients in the Amathole District Municipality. Their working relationship with allopathic health practitioners is formalised through the Application of Health Standards in Traditional Circumcision Act, Act No. 6 of 2001, as was mentioned earlier in this text.

Arguing in favour of allopathic health practitioners, one participant stated that doctors probably did not refer patients as they might not know those who warranted referral to traditional healers. He further expressed the view that the allopathic health practitioners’ knowledge of disease causation was limited. He maintained that doctors, for instance, were not aware that there were three types of diseases as determined by their causation. There were natural diseases caused by natural forces and germs, for instance, measles. There were man-made diseases due to witchcraft and lastly, there were diseases of cultural origin caused by failure of the patient to perform a cultural ritual aimed at maintaining his/her health. An example of such a disease was said to be enuresis among persons over 10 years old. He then concluded that doctors would therefore, not be able to diagnose and refer patients with man-made diseases and diseases of cultural origin. As a matter of emphasis, the participant raised this point thrice:

“ Let me explain this thing clearly. A person is sick, because there are three things that make a person to be sick. There are only three. It’s natural diseases, that’s the first one. There are many such diseases-things like measles, for
instance. The second cause, she is sick, because of her ‘home things’ (izinto zakowabo). Maybe she needs a ‘cultural necklace’ (intambo) or a cultural ritual like ‘imbeleko’ for enuresis in a person over 10 years. The third one is a ‘deliberate thing,” a man-made disease (yinto yangabom). You see now, doctors will not be able to treat your ‘home thing’ or refer you. Those instruments will not say this is a ‘deliberate thing’ that this person is suffering from. But with natural diseases, the instruments will tell.”

The participant felt strongly about man-made diseases and maintained that these were caused by witches. He argued that the existence of witches who were responsible for inflicting the man-made diseases on their enemies, should not be doubted or discounted; for the mere fact that there was the word “witch”, suggested that witches existed because a name was never given to a non-existent entity. One participant did state though, that the western-trained health practitioners would not be able to refer patients to traditional healers until the professional councils controlling the practice of allopathic health practitioners approved the issue of referral of patients by allopathic health practitioners to traditional healers. Highlighting this point she said:

“The western trained will say no, I cannot refer, I will be breaking my Council rules.

A similar notion is upheld by Troskie (1997b:37) who feels that a controlling body regulating the practice of traditional healers would probably make provision for referrals from both practices as currently, because of legislative policy it would not be possible for medical practitioners to refer patients back to the traditional healers.

A number of researchers have commented about the negative attitude of allopathic health practitioners towards traditional healers especially in relation to the referral system. A study by Ojanuga (1981:408) to determine the attitudes of
traditional and medical doctors towards each other and the conditions under which they would agree to integrate, revealed that 76% of medical doctors said that they would never under any circumstances send a patient to a traditional doctor for treatment. Khokho (in Melato, 2000:64) commenting on the relationship between traditional healers and the hospital doctors, states that western trained doctors do not refer patients back to traditional healers because of their negative attitude towards the practice of traditional healing. Hopa, Simbayi and Du Toit (1998:86) looked at the perceptions of various stakeholders with regard to integration of traditional and western healing in the new South Africa. They found that medical doctors adopted a negative and superior stance towards traditional healers. Apart from questioning the authenticity of the traditional healing practices, the doctors in the study by Hopa et al.(1998:87 &91) thought that traditional healers were mostly illiterate people who believed in cheating.

On the other hand, findings from other studies support the notion of a reciprocal referral system between traditional and allopathic health practitioners. In Peu’s study, for instance, 91.2% of the participants suggested the creation of an officially recognised referral system between traditional healers and community health nurses, the rationale being that both types of practitioners were consulting patients (Peu, 2000:127). In a study conducted by Bodibe (in Foster, Freeman & Pillay, 1997:87) into the inclusion of traditional healers in mental health, the traditional healers who participated in the study interpreted cooperation to mean that a referral system would be utilised in terms of which the mental health team would refer patients to them and they (traditional healers) would do the same. A similar opinion was expressed by Mototo (1999:93) who felt that if there was teamwork, western people would no longer refuse to refer patients, especially those talking about ancestors and tikoloshe. Wessel (in Troskie, 1997b:31) also suggests that to facilitate collaboration with traditional healers, there is a need to pay attention to the issue of a mutual referral system.
Mulaudzi (2001:19) sums this up by asserting that mutual referral is only achievable in a climate in which people respect one another’s uniqueness and competency. She then advises that healers from the respective backgrounds should have basic training pertaining to each other’s medical expertise and such mutual interchange would benefit both patients and practitioners.

Findings by Peltzer and Khoza (2002:33) differ from those of other researchers that have just been discussed above. In a study conducted on the attitudes and knowledge of nurse practitioners towards traditional healing, faith healing and complementary medicine in the Northern Province of South Africa, they found that between 14% and 26% of nurse practitioners had referred patients to ethnomedical practitioners. One of the common reasons for such referrals, as stated by the participants in that study, was that those nurses had personally experienced the benefit from traditional healers.

Despite the unpreparedness of allopathic health practitioners to refer patients to traditional health practitioners, the latter group stated that they continued to refer patients to allopathic health practitioners especially dehydrated, very weak, pale, dyspnoeic and psychotic patients as well as those experiencing difficult labour. These patients were being referred for rehydration, stabilisation and appropriate management. Traditional health practitioners acknowledged that they were referring the patients because allopathic health practitioners had the knowledge, skills, technology and equipment to investigate diseases and manage the patients. Comments from the various categories of traditional health practitioners concerning the reason for continuing to refer patients to western-trained practitioners were as follows:

“A person comes to you weak, you see that you cannot treat him with Xhosa medicines, he must first get an injection or a drip especially sometimes a person does not eat. It’s like a person who comes to you mad, you see it is because of ‘amafufunyana’ and he is too wild. If a person is too wild he must first get an
injection from the doctor and he becomes tame and comes back, then I get a chance to give him something for ‘amafufunyana.’”

“When vomiting, feeling weak and I see his blood is short of water, maybe he has diarrhoea with sunken eyes, the skin of the body is not likeable, it appears wrinkled, that person, I send to a doctor.”

Traditional birth attendants uttered the following statements:

“Personally I feel we must hand over to doctors, especially difficult labour. Doctors appear to have a good “hand” because they are educated. A doctor can see inside a person and see the position of a baby. They use instruments and see things that are inside.”

“Even if you are going to get a baby that is dead, the doctor has already seen that. Here at home I can’t see those things.”

Another participant stated:

“Here in the circumcision rite, we traditional surgeons do not have surgical blades. This blade is with the western people. That is why I am saying we have to depend on the western people.”

These statements illustrate the confidence that traditional health practitioners have in allopathic health practitioners in managing certain illnesses.
3.2.3.2 THEME 2: THE NEW TRADITIONAL HEALTH PRACTITIONERS ACT WAS PERCEIVED BY TRADITIONAL HEALERS AS HAVING BOTH BENEFICIAL AND THREATENING ELEMENTS RELATED TO THEIR PRACTICES.

Participants expressed mixed feelings regarding the impact that the new legislation on traditional healing would have on their practices. They foresaw some advantages or benefits whilst also being concerned about the disadvantages or threats that would emanate from the implementation of the Act. This ambivalence was also noted by the researcher when she attended a conference on traditional medicine in Kopanong, Gauteng Province in June 2006 where a group of traditional healers rendered a musical item that relayed a message about the stress and worry caused by the Traditional Health Practitioners Act. In the same breath, there was loud applause and whistling from the same traditional healers when certain provisions of the Act were explained by the various speakers during deliberations in the conference.

The perceived beneficial and threatening elements of the Act will be discussed as sub-themes of this theme.

SUB-THEME: PERCEIVED BENEFICIAL ELEMENTS OF THE ACT.
Elimination of unscrupulous practitioners, economic benefits and occupational protection of the traditional health practitioners were highlighted as the beneficial elements of the Act related to the practices of traditional health practitioners.

A. Elimination of unscrupulous practitioners
Participants welcomed the Act, anticipating that it would assist in eliminating unscrupulous practitioners, that is, individuals who purported to be traditional health practitioners exploiting the profession for pecuniary reasons. These included people who pretended to be traditional surgeons and performed botched circumcisions and penile amputations on initiates. There were isolated
reported cases of deaths of the initiates throughout the Province of the Eastern Cape resulting from dehydration, excessive bleeding, poorly managed wound care and delayed referral to the hospital, all this reported to have happened at the hands of inefficient traditional surgeons. Other unscrupulous practitioners were individuals who treated patients under the pretext of being herbalists using herbs that they had ordered from advertising companies through catalogues or purchased from street vendors. Others pretended to be diviners without having undergone the “thwasa” process. These self-proclaimed practitioners were said to be tarnishing the image of the traditional health practitioners. One participant had this to say:

“Maybe this Bill will control the fly-by-night people, that is, people who are not called by the dream.”

This was alluded to by another participant who said:

“It is going to help as there are people who overnight become traditional surgeons, because of chasing money. They do things that they don't know, killing or maiming other people’s children.”

The existence of another rare type of unscrupulous traditional healer surfaced when the researcher was conducting individual interviews. Three of the participants expressed concern about traditional healers who acquired traditional healing by other means. Reference was made to practitioners who had gone through the “thwala” process instead of the “thwasa” process. “Thwala” literally means “carry” especially on your head, but figuratively, refers to acquiring a skill, knowledge or wealth by sinister means. These practitioners were alleged to be individuals who were desperate to attract more clients being driven by greed for wealth and would go to “thwala” from another herbalist. The nature of the herb, object, creature or being through which the “thwala” process is acquired, could not be established by the researcher in this study. The researcher probed in vain
to get a sense of what form this “thwala” took and whether patients were more effectively treated if a practitioner had “thwalad.” Participants became very evasive on this issue giving the researcher the impression that she was “treading on dangerous ground.” The following statements were however, uttered by the participants:

“‘There is now this film of the ‘amakhosi’ which has spoilt something that is traditional…Once a traditional healer puts on these ‘things’ (participant mentions the ‘things’ but the researcher is avoiding to state them due to sensitivity of the matter), he/she is no longer a traditional healer, he/she has acquired the skill through other means-has ‘carried’ (uthwele). He is greedy for something and will be given the ants from the graves-amakhosi.”

Another participant offered this cautionary perspective:

“My sister, we are not the same. I must tell you, we differ because another person treats people meanwhile he has ‘thwalad.’ He undergoes the ‘thwala’ process and is given the ‘things’…..He lacks the knowledge of traditional medicine in his blood.”

One participant mentioned that she was particularly perturbed by individuals belonging to the white racial group who pretended to be undergoing the “thwasa” process while they were undertaking research (doing participant observation). She argued that the white traditional health practitioners never performed the rituals associated with traditional healing in their own homes to meet their but performed them at the homes of their black mentors, contrary to the normal practice. Arguing this point emphatically, she said:

“You see, I have a problem with the way whites ‘thwasa’; and I regard it as participant observation. I have not seen a white taking a diviner mentoring him/her to his/her home at the Van Riebeecks, introducing him/her to the Van
Riebeeck ancestors and the family members slaughtering a beast. What happens, a white just comes to the Dlamini mentoring diviner’s home all by himself/herself and because of having the colonial mentality, I become excited as a mentor and say “Oh Oh, a white person has come to my home and allow him to get into the Dlamini kraal and slaughter his/her goat. That is an unknown culture! It is not the proper thing; that as a white….it’s worse now that some even have Dlamini clans. He/she has a clan but cannot evoke the ancestors by clan name.”

The issue of whites heeding the ancestral call was a subject of debate in the local newspaper, the Daily Dispatch dated Saturday, 8 October 2005 (Feni, 2005:6). In this article, Nokuzola Mndende and Ntombekhaya Luke, who are both traditional health practitioners, dismissed white diviners as fakes or researchers who wanted to infiltrate the culture for their own personal gain, while Ziphathe Manxele who had trained six whites including one from Denmark and another from Germany, saw nothing wrong with white diviners, but indicated that what made him unhappy, were the laptops that they had brought with them to record information into (Feni, 2005:6). Peggy Dasi, who is a nurse and a traditional healer, argued that the African way of “ukuthwasa” was solely for African people and that had nothing to do with racism but with culture and identity. Her viewpoint is shared by Mfuzi who stated that Whites, Coloureds and Indians could be traditional health practitioners but within their own cultures. Reid and Suskin, commenting on the same topic, argued that Whites had ancestors as well and to be a diviner was to be called by them but they did not elaborate as to why the rituals associated with divinity were not conducted in their homes. The chairman of the Eastern Cape Traditional Health Practitioners Association, Solly Nduku, summed up this debate by stating that the authenticity of white diviners (izangomas, amagqira) remained a challenge within his organisation (Feni, 2005:6).

Mafalo (in Melato, 2000:32 & Hopa, Simbayi & Du Toit, 1999:91) also raise concern about the risks that patients are subjected to because of the rising
number of “artificial healers”, charlatans or quacks who are invading the practice for gain. As the Act requires compulsory registration of all traditional healers and supervision of their practice, participants expressed the hope that this might assist in identifying and eliminating the quacks.

B. Economic benefits for traditional health practitioners

The economic benefit anticipated by the participants from the Act was the remuneration that traditional health practitioners were hoping to receive from the Medical Aid Schemes after consulting patients registered with the schemes. This was commented on by one participant:

“People are looking forward to benefit from the Medical Aid.”

Commenting on the anticipated benefit from Medical Aid Schemes by the traditional healers, Bhengu (2004:26) raises concern over two issues. Firstly, the herbs used by the traditional healers and the categories of practitioners within the traditional healing system have both not been scientifically defined as is the requirement of the Medical Aid Schemes Amendment Act, Act 55 of 2001. Secondly, if accepted by the Medical Aid Schemes, traditional healers would have to adapt to global accounting systems used largely by the computer-literate medical fraternity. She advises that Medical Aid Schemes should then run workshops for traditional healers to ensure the smooth running of the system.

Another anticipated economic benefit was that herbalists and diviners would be able to negotiate with the government for the provision of land for the cultivation and conservation of specific medicinal plants in their areas to prevent extinction of those plant species that are utilised for medicinal purposes. In addition, because they would then be recognised practitioners, permission could also be sought from government to allow them to hunt for certain animals for medicinal use while using skins and hides of those animals for their traditional garb. Expressing this viewpoint one participant had this to say:
“I believe that they can be allowed to enter certain forests and certain camps to get the herbs and certain animals. As it is with Whites, there are certain times that are called hunting seasons. They will have the authority to hunt the animals that they want and the ‘trees’ from which they will get their herbs, if they can come forward and not hide themselves.”

“Because certain trees and animals are protected by government laws, if they can accept change, it can be easy to get these.”

In advocating for a synergy between indigenous knowledge systems, the modern healthcare system and scientific research, Mulaudzi (2001:17) highlights another dimension of economic benefit for traditional healers, namely, the creation or establishment of Indigenous Knowledge Systems Departments in Universities. This would provide traditional health practitioners with access to laboratories and pharmacy departments where their traditional medicines could be tested for safety and efficacy.

C. Occupational protection of the traditional health practitioners

Participants anticipated that the Act would provide some protection as they would be recognised as practitioners in their own right. One participant narrated instances when she had to negotiate and pay a medical doctor to take ownership of the patients who had died in her care.

“Then I had to send him to a medical doctor already dead so that he could get a certificate from Home Affairs. I am forced in such cases to ‘buy’ a doctor so that it appears as if the deceased was under his care.”

One participant further suggested recognition of their training institutions (amaphenhlo) by the Interim Council for the Traditional Healers in South Africa, so that as a mentor she could sign and issue certificates to her trainees on
completion of their training to indicate that the graduated trainees were now fully-fledged practitioners.

“That is why I was suggesting that there should be recognition of the ‘amaphehlo’ (training schools). The mentoring diviner is going to announce that this one has been healed, he has his oxtail, I have trained him.”

The newly-graduated traditional health practitioner would then operate freely knowing that certification had been received from an approved and recognised training institution.

Another wish that the participants expressed was to be granted authority as practitioners in their own right, to issue sick certificates to their clients. They maintained that this would protect their clients as well. Excerpts from the participants were:

“We traditional healers should be given authority to give people sick certificates because really we keep a person treating him/her even through the seclusion ritual. Now when she goes back to work, money is deducted for the days that he/she was absent from work. Another one gets fired. You see now, I have not given him/her a letter that says he/she was really sick.”

Another participant also commenting on issuing of certificates

“There is something that ‘beats’ us. You see that this person should be with you for about a week, but you are being ‘beaten’ by the law because you are unable to issue a paper.”

“I so wish we could be allowed to issue the ‘papers’ because we don’t have such permission now.”
Authorisation of traditional health practitioners to issue sick certificates to their patients was a subject of discussion as far back as 1998, when Provincial Public Hearings were conducted (Public Hearings, 1998). At the end of this exercise various provinces suggested that the matter be deferred for a decision by the Interim Traditional Health Practitioners Council.

Mototo (2000:96) pointed to the fact that the official registration of traditional healers would afford them the opportunity to be known, to practice freely without having to hide and to receive monetary incentives from the government for input with regard to some health issues. Furthermore, their discoveries of medicines would be tested, approved and recorded, thus promoting their image. The issue of protection of traditional healers was also raised by Moropodi (2004:26) who argued that whenever a patient died in the hands of a traditional healer, an aggressive policeman would come to arrest the traditional healer; meanwhile if the same happened to a medical doctor, he would just file a report and be left in peace. This was the kind of protection that she felt was also required by traditional health practitioners.

**SUB-THEME: PERCEIVED THREATENING ELEMENTS OF THE ACT**

Participants, especially those who were not well educated, perceived the Act as threatening their practice. Some were even contemplating abandoning their practice. One participant expressed this threat:

“I hear the voice of too much detail. I am abandoning the practice.”

On being probed on the meaning of “the voice of too much detail,” the participant was apparently making reference to detailed lengthy meetings that he had attended, where traditional health practitioners were being introduced to the new Act by health officials from the provincial office of the Eastern Cape Department of Health. The participant felt that the detailed explanation about the provisions of the new Traditional Health Practitioners Act, Act 35 of 2004 and the inherent
compliance issues that were highlighted by health officials, were too
overwhelming. What was particularly threatening was the fear of being arrested
and the possibility of being forced to divulge information pertaining to their herbs.

A. Fear of being arrested for errors in practice
Participants expressed their fear of being arrested for errors that they might
make in their practices. Traditional birth attendants, in particular, indicated that
they were not keen to continue with the practice in case something went wrong
with the baby or mother, as they would have to account for why they did not
summon a doctor.

“I think in case an unusual error happens, then, I am taken and arrested. You
see, I don’t want to be arrested. This Act is threatening..........the illiterate, worse
to us, the illiterate.”

Traditional birth attendants also indicated that errors involving the death of a child
or mother had occurred very rarely in the past, but the incident would end there
and the patient would be buried with no formal reporting of the death to the
government authorities except to the headmen and chiefs. They, however, stated
that they had never personally experienced such mishaps. The researcher noted
that two of the three participants were not merely expressing their fear, but were
also sweating with shaking hands and trembling voices as they spoke. The
researcher felt compelled to put the participants at ease. As indicated in the
previous chapter, the two participants had also organised local women to be
present during the interview. This fear was also expressed by another participant:

“We are now scared to conduct deliveries because things have changed, it’s not
like before. We are panicking in case labour is delayed or the mother dies, then
you are in a latch. You can be arrested and asked ‘what have you done to this
person?’ “
The fear of being arrested was associated with the arrests of traditional surgeons who had performed circumcisions illegally throughout the province in the previous year. At the time, that is, in the year 2003, it had been reported that 41 initiates had died, 29 had botched circumcisions and 311 had been admitted to various hospitals in the province. Consequently the traditional surgeons responsible for this mismanagement of initiates were arrested. The relation of their fear with the arrests of traditional surgeons was actually stated by the participants.

“The day they ask, ‘Where is your licence, where were you educated/trained?’ Things like that, and who am I, Mhm? It’s just like those traditional surgeons who are now simmering in prisons.”

One participant indicated that in the past, if the patient developed complications after consulting a traditional healer and had disclosed this to the doctor, the matter would be investigated by policemen who would demand to see his permit to treat patients. This then encouraged people to utilise the services of traditional healers clandestinely to protect the healer. As the participant said:

“You know, if you were a traditional healer in the olden days, and this will never stop, if a patient told the medical doctor that he had consulted a black man, this would be investigated to find out where this person was. Police would arrive and want to know how you operate and where is the certificate that shows that you are a traditional healer.”

At this juncture the participant who made this remark quickly stood up and showed the researcher a certificate that was hanging on the wall, issued to the healer in 1982 by the South African Herbalists Association under the auspices of the South African Medical, Dental and Pharmacy Council authorising him to practise as a herbalist. This action reinforced for the researcher the importance that the participant ascribed to the legal aspects pertaining to his practice.
B. Obligation to divulge information relating to traditional medicine

Participants were concerned that the existence of this Act might compel them to divulge information relating to the herbs/traditional medicines that they were using and the disease conditions for which they were used. As they had obtained part of their knowledge from their ancestors through dreams and “voices”, they felt that divulging this information would subject them to the wrath of their ancestors. As one participant remarked:

“Because I am sent by those underground, if they can see me sharing information about my herbs with other people, they can say, ‘Oh, this child, what is he doing now? Why is he handling our things like that? Why is he giving away these things?’ Because I am working on instruction, mos, I can suddenly see dwindling of clients or dying of patients under my care.”

A similar concern was stated by another participant:

“What I cannot do is to take a ‘tree’ that my father showed me, that belongs to the Mchobongu clan, and give it to others, give it to the doctor. I would rather abandon traditional healing than share my knowledge with other people. My ancestors will hit me; they will desert me and take away their herbs.”

In addition, there were fears that allopathic health practitioners would steal this information on herbs to manufacture new medicines in laboratories and then sell them at a high price. This concern was also voiced by a Group 1 participant highlighting the fears of traditional healers.

“We know that they say western people will take their medication, test it and develop another treatment and then think they are the best in treating a certain condition whereas they got the combination of the medication from traditional healers.”
Similar fears were noted by Mototo (1999:97-98) in her study of the willingness of traditional healers regarding collaboration with western psychiatric healthcare practitioners. In Mototo’s study, traditional healers indicated that they received instructions from the ancestors regarding treating patients. They believed that this was a secret given to them by their ancestors; therefore they were carefully safeguarding it, fearing that the ancestors would be angry and punish them heavily if they shared that information. Mototo’s participants had further expressed fear of losing their intellectual property rights. Their feeling was that western health workers would steal knowledge from them to improve their own practice. Jones (1998:1060) also noted that some traditional healers remained skeptical about the reason for the sudden increased interest in their practice. They feared for the possibility of it being the Government’s attempt to invade their practice. Kubukeli (1997:917) also commented about this fear stating that traditional healers were concerned about the ownership of their knowledge and feared that it could be stolen. In a nationwide survey of healers, Erinosho and Ayorinde (in Odebiyi,1990:340) revealed that illiterate practitioners were less likely than those with some formal schooling to agree to divulge their secrets to the government in exchange for official recognition. The issue of secrecy was peculiar to particular types of traditional healers. This confirmed the researcher’s observation in the present study that illiterate or poorly-educated diviners and those herbalists who claimed to have been endowed with the knowledge of herbs by their ancestors, tended to be secretive and not prepared to share information regarding their traditional medicines. The very secretive healers were also very confident about their healing ability and even communities appeared to hold them in high esteem. The researcher was also aware of the popularity of some of these traditional health practitioners.
3.2.3.3 THEME 3: TRADITIONAL HEALTH PRACTITIONERS SUGGESTED POSSIBLE AREAS OF COLLABORATION.

Participants were generally in favour of working in collaboration with allopathic health practitioners; but they clearly stated that the two systems should run parallel with identified areas of collaboration. The notion that the two systems should run parallel was suggested by a number of participants:

“This is a profession on its own right, that has to stand on its own.”

Another participant in an obviously irritated tone said:

“I sometimes hear talks about integration. The question of integration---let’s forget about it. These are parallel lines.”

This viewpoint was also shared by another participant:

“Doctors and nurses must do their thing and we do ours separately.”

The same sentiments were shared by the head of the Traditional Healers Association, Maseko (in Hess, 1998:6), who stated that the two systems were far too different to be totally fused and supported the establishment of a traditional system which would run parallel with the modern health system.

The term “collaboration” is perceived and applied in various ways by different authors and researchers, but Troskie (1997a:15) defines collaboration as a process of working together in a climate of provision of mutual assistance and help by two parties to attain a common goal. As was mentioned in chapter 1, Spradley and Allender (1996:291) further highlight four characteristics that distinguish collaboration from other types of interactions, namely, shared goals, clear responsibilities, mutual participation and use of resources. They state that the team members enter into the collaborative relationship with a specific purpose and objectives to be attained. In this study the participants highlighted that they had a common goal with allopathic health practitioners, that of healing a
patient. It was therefore imperative that they should work together. The essential factors in collaboration as highlighted by Axinn & Axinn (1997:107) are trust and respect for the competence of individuals involved, with each participant having something to offer to the other and willingness on both sides to invest time and money in sufficient communication. In the present study it surfaced that the relationship between traditional and allopathic health practitioners was affected by elements of mistrust and disrespect caused by a lack of knowledge about one another’s abilities and healing methods. One participant made this remark:

“..You see, I sometimes do not know how collaboration can be done because the ‘western’ are not satisfied or convinced about our things.”

A feeling of mistrust is not only directed to colleagues that are operating in the healthcare delivery spectrum, but also levelled against the authorities managing health services. This is noted in the statement by one participant:

“I can see what the ‘Department’ wants, it wants to swallow traditional healers. It wants them to practise in hospital premises. You see, that’s not it. They are cheating us.”

Coleman (in Burley, Mitchell, Melling, Smith, Chilton & Crumplin, 1997:78) sums up this ambivalence in the following statement:

“It has been argued that although collaboration is generally recognised as productive and useful in the provision of healthcare, there remain conflicts and obstacles to joint working with the difference in academic levels being cited as pervading the professionals’ attitudes towards each other.”

Pietroni (in Burley et al., 1997:82) also discovered that over and above professional rivalries and ideological differences, difficulties in collaboration arose
as a result of competition for resources, role overlap and a lack of knowledge of each other's language.

Participants in the present study suggested identification of areas of collaboration between practitioners of the two health systems as currently the traditional healers seemed to operate outside the formal health structures.

Madamombe (2006:11) sounds a warning that sideling traditional healers can have serious consequences as some patients preferring the healers, may disregard their doctor's advice or take herbal medicine that could have dangerous interactions with pharmaceuticals. A similar notion is held by Vongo (2006:1) who states that allowing the divide between traditional and medical doctors to continue may result in traditional healers becoming counterproductive as they have the authority to command any patient to discontinue the medical doctor's prescribed medicine. As somebody who grew up in the Amathole District Municipality and is from the Xhosa culture, the researcher is also aware that most patients belonging to the Xhosa ethnic group, tend to adhere strictly to the instructions of the traditional healers (especially diviners) pertaining to treatment, as they have the notion that the healer has special powers that enable him/her to see, detect or sense any violation of or non-compliance with his instructions. Patients are thus inclined to be loyal to the traditional healers and ignore the treatment prescribed by the allopathic health practitioners. The researchers quoted above are of the opinion that if patients get to know that there is collaboration between allopathic and traditional health practitioners this tendency of ignoring the medical doctor's prescription in favour of the traditional healer's treatment, can be avoided.

Isolated examples or pockets of collaborative efforts exist throughout South Africa although most of them are not formalised. One of the collaborative projects that can be cited is in the Western Cape where traditional healers have been involved in the drafting of Traditional Medicine Formulary together with the Traditional Medical Research Unit (TRAMED) at the University of Cape Town.
Cultivation of traditional medicinal plants in collaboration with organisations such as the Western Cape Nature Conservation Department and the National Botanic Institute is another example of collaborative work between allopathic and traditional health practitioners (Kubukeli, 1997:917).

Collaborative work is also taking place in KwaZulu Natal. The Department of Family Medicine at the KwaZulu Natal University for instance, gives lectures on Complementary Systems of medicine for undergraduate and post-graduate medical students in order to build their capacity in this area. Traditional healers are also exposed for five times to a one week long training course on HIV awareness, Voluntary Counselling & Testing, Home Based Care and Antiretroviral therapy awareness five times (Hartzell in Smart, 2005:1). In a workshop attended by the researcher in Gauteng province on institutionalisation of traditional medicine in June 2006, one of the Commissions was assigned to discuss the issue of collaboration. One of the recommendations made by the Commission was that there should be amendment of laws to facilitate collaboration in so far as referrals were concerned in the best interests of the patient. The Commission further called for the development of education programmes that would improve collaboration, and that these be accredited by the respective Councils.

In the present study, traditional health practitioners shared their opinion on what they viewed as collaboration and on possible areas of collaboration between traditional and allopathic health practitioners. These areas of collaboration were then identified as sub-themes and the researcher will now discuss them.

**SUB-THEME: THESE AREAS OF COLLABORATION INCLUDE:**

**A. Sharing of resources**

One of the mechanisms of promoting collaboration between traditional and allopathic health practitioners as stated by the participants was sharing of...
resources. The resources ranged from the budget, physical health facilities like hospitals and clinics, equipment and information.

- **Budget**

  The participants felt that to play their role as health practitioners successfully, they required a budget which would fund the new structures to be established to control the practice of traditional health practitioners, namely the provincial, district and sub-district committees. The budget would also fund the programmes that had been developed by traditional health practitioners. The need for a budget was emphasised by one of the participants:

  "*We have put our programme down. We need resources. A programme mos requires a budget.*"

  The issue of a budget for traditional health practitioners is also supported by Kubukeli (1997:917) who argues that since traditional healers treat about 80% of the population, they ought to share in the country’s budget. Freeman and Motsei (1992:1188) appear to have some reservations about accommodating an estimated 150,000 traditional healers in the country’s budget. They maintain that the health budget in South Africa is already stretched to the point where inadequate services are provided and staff underpaid.

- **Physical health facilities**

  Although some participants expressed the need to be provided with health facilities in which to perform their healing practices, there were divergent views regarding the location and utilisation of these facilities. Some participants, except traditional surgeons and traditional birth attendants, suggested that they be allowed to enter clinics and hospitals to provide follow-up treatments to patients that they had consulted in the village before admission to hospital. Others were not in favour of treating patients within hospital premises as they maintained that conditions in the hospital were not
suitable for their healing methods. Excerpts of their contradictory views on this matter are given below:

“Even now there are people who want to be allowed to enter the hospital and treat patients. I don’t oppose that strongly, but I am saying the healer must visit his patients only and give them the medicines that he wishes to give to his patients.”

Another participant articulated the following view:

“My view is that we need to work together, but not in the sense that we go up and down in the wards as I sometimes hear some traditional healers wishing. The thing is, the doctors always say ‘Fresh air, fresh air’ for patients, meanwhile I’ll be ready to fumigate with herbs for a patient suffering from severe headache.”

Others suggested that a separate clinic be erected on the hospital premises solely for use by traditional healers and should display such signage. Another view was that traditional healers be allowed to work in the same clinic as allopathic health practitioners sharing all resources and with cross-referral of patients occurring under the same roof. One participant voiced a different viewpoint:

“I sometimes hear about those people who want to be given a section in the clinic or be allowed to go and treat their clients in hospitals and clinics. Anyway those are the herbalists. No, I don’t see that well.”

The point raised was sharing of these facilities with allopathic health practitioners with no mention of sharing costs for use of water, electricity and furniture in those facilities. What was emphasised was that such an
arrangement would offer patients freedom of choice regarding the type of healer whose services they required at that time.

The provision of working facilities for traditional healers is a subject that was raised as far back as 20 years ago. For instance, in a study conducted by Ojanuga (1981:410), doctors who participated in that study suggested that traditional healers should have their own hospitals and those running herbal healing homes be given government subsidies for capital development as these homes were often located in areas where there were no hospitals. In the current study the need to provide housing subsidies for traditional health practitioners was also raised by a participant in Group 3, that is, a nurse who is also a traditional healer. She raised concern about the unfavourable conditions under which some mentors practiced and cited a situation of her mentor who had to accommodate about fifty trainees in one shack.

- **Equipment**

  Provision of equipment was mentioned mostly by traditional birth attendants and traditional surgeons. These are excerpts from two participants:

  "I am advising that government should give people something to help and support them….gloves,"

  "We need to be provided with things to heal the wound, like Betadine, Furacin and Zambuk that I mentioned earlier."

  The need to provide traditional health practitioners with equipment is also supported by Hartzell (in Smart, 2005:2) who quotes a situation in KwaZulu Natal where, most traditional healers work in resource-constrained settings, seeing an average of five HIV-positive patients a day and yet most of them did not even have rubber gloves. A study conducted in KwaZulu Natal by Hovland on the knowledge and attitudes of traditional birth attendants towards
HIV and AIDS and their beliefs related to perinatal care, also revealed a need to provide traditional birth attendants with equipment like transport and delivery packs as well as to assist them with disinfection of their delivery equipment (Mchunu & Bengu, 2004:49).

- Information

Participants suggested that campaigns be held to share information and create awareness in both allopathic and traditional health practitioners about the situation brought about by the new Traditional Health Practitioners Act. Information obtained from the participants during individual interviews indicated that there was currently no formal forum for mutual communication between medical doctors and traditional healers in the Amathole District Municipality. Participants pointed out that there should be openness between the different health care workers to avoid misunderstanding.

Regarding sharing of information pertaining to the patient, Hartzell (in Smart, 2005:2) emphasises the need to clarify confidentiality issues first, before doctors will feel free to share patient information with the traditional healers. Coming from the same cultural background the researcher is also aware of lack of confidentiality, especially among the poorly educated traditional healers, about a patient’s illness and treatment. The researcher encountered this in the present study especially among herbalists and diviners who, during debriefing mentioned politicians, religious leaders and high-ranking government officials who were using their services and they were calling them by names. The following quotation illustrates this tendency:

“Nurses, high class people who are residing in town, in King William’s Town, faith healers, are being treated by me. They frequent this place. Even politicians ("So and So,… So and So… and So and So-calling them by names) used to come here. They promised that I will be buried by the
government when I die, so now I am charging R150 instead of R500 as ‘my beast.’ I want politicians to speak nicely about me on the day of my funeral.”

“Do you see that…next to the taxi rank in King William’s Town, I cured the mother of that black guy working there who was suffering from cancer of the uterus.”

B. Role clarification regarding disease management

Successful collaboration depends on the participants’ understanding of their individual roles. The issue of role clarification especially pertaining to disease management was succinctly explained by one participant as follows:

“It’s like a person with pubic lice, ‘ifufunyane,’ or being eaten by the lightning bird, or poisoned, I can’t finish them all. Those are ours. Doctors must not keep those patients there and by the time they get to us they are a problem. We too, if we see through our ‘trees’ that this one has ‘stones’ or requires an operation, he/she must go to the white doctors. We need to differentiate these diseases and say these are yours, these are ours.”

It was noted from the remark made by one participant that the need for role clarification is not only applicable to the situation between allopathic and traditional health practitioners but also between the various types of traditional healers. Perturbed by the fact that diviners had started practicing as healers as well, he pointed out that diviners were traditionally diagnosticians only and did not dispense medicines. Expressing his concern he said:

“According to my knowledge, diviners don’t treat. A diviner is ‘white.’ There are herbalists that the diviner refers to and will say, ‘Go to that herbalist and tell him that I’ve said you are suffering from this and that.’ Since I was born, the situation was like that.”
This viewpoint was supported by another participant who commented:

“Like I can attend to a patient with a social problem, a problem that is in his/ her home and then be requested by him to help. So I too, because of a need for money, decide not to refer to a herbalist and say, ‘All right I will do it for you.’ I am taking the herbalist’s job!”

To clarify the roles of different categories of traditional healers, participants advised the establishment of a database of all traditional healers in Amathole District Municipality and this should reflect their area of specialisation.

“I am one of the Provincial Executive Committee members in the Buffalo City. I register them. The database is there, it’s available as I speak. Once the Council is in full swing, it will be clear that this one specializes in this way and another one that way.”

Chipfakacha (1994:862) advises that traditional healers should be encouraged to refer patients they are incapable of treating. Freeman and Motsei (1992:1184) explain that in collaboration both traditional and western systems remain essentially autonomous and each retains its own methods of operation. The practitioners from the two systems co-operate through the recognition of the health value of the other. This co-operation may take the form of mutual referral. Practitioners from both paradigms would recognise the efficacy of the other in the treatment of a particular disorder and practitioners would come to an agreement as to what disorders should be referred to whom. Wessels (in Troskie, 1997:31) advises that to enable collaboration with traditional healers, their frame of reference should be known and the acknowledgement that there are certain illnesses that traditional healers can treat more effectively should be done. This is also alluded to by Pretorius, De Klerk and Van Rensburg (in Troskie, 1997:38) who state that in order to promote collaboration, the diseases that are treated successfully by traditional healers should be identified.
3.2.4 FINDINGS FROM GROUP 3: NURSES WHO ARE ALSO TRADITIONAL HEALERS

This group was selected using snowball sampling. The aim was to elicit viewpoints of health practitioners who had the knowledge and experience of both worlds, namely western and traditional healing systems. Three of the participants were still actively practising the nursing profession while one had retired a few months before the interview. Two were residing in the same urban area, one in a township and the other one in a rural village. The profile of the four (4) participants forming the group of nurses who were also traditional healers was as follows:

Table 3.6: PROFILE OF NURSES WHO ARE ALSO TRADITIONAL HEALTH PRACTITIONERS.

<table>
<thead>
<tr>
<th>GENDER</th>
<th>RACE</th>
<th>EXPERIENCE</th>
<th>LOCATION</th>
<th>RANK</th>
<th>ALLOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>As nurse</td>
<td>As traditional healer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>27</td>
<td>5</td>
<td>Buffalo City</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>13</td>
<td>9</td>
<td>Buffalo City</td>
<td>Enrolled nurse</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>31</td>
<td>7</td>
<td>Amahlathi</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Female</td>
<td>Black</td>
<td>22</td>
<td>3</td>
<td>Buffalo City</td>
<td>Registered nurse</td>
</tr>
</tbody>
</table>

All the interviews were held in the homes of the nurses who were traditional healers. Although the participants were health professionals with a good understanding of English, the interviews were conducted in Xhosa to accommodate the jargon of traditional healers. Only one of the participants had clients at the time of the visit. The interviews lasted between one and one and half hours.
Three themes emerged from the individual interviews of this group. These were:

- Participants experienced role conflict at different levels while working in the clinical situation.
- Participants had a perception that the Act would create opportunities for them.
- Participants advocated for capacity-building of traditional and allopathic health practitioners in preparation for facilitating collaboration and cross-referral.

The themes and their sub-themes are depicted in the table below:

Table 3. 7: IDENTIFIED THEMES AND SUB-THEMES RELATING TO GROUP 3: NURSES WHO ARE TRADITIONAL HEALTH PRACTITIONERS

| MAIN THEME                                                                 | SUB-THEME                                           |
|                                                                           | 1.1  | Nurses experienced role conflict related to: |
| 1. Participants experienced role conflict at different levels while working in the clinical area. | 1.1.  | A. their own professional role |
|                                                                           |      | B. expectations from colleagues and |
|                                                                           |      | C. expectations from management |
| 2. Participants perceived that the Act would create opportunities for them. |      | ___ |
| 3. Participants advocated for capacity-building of traditional and allopathic health practitioners in preparation for facilitating collaboration and cross-referral |      | ___ |
The researcher will now discuss each theme and sub-theme highlighting the facts by using quotations from the participant’s transcribed interviews.

3.2.4.1 THEME 1: PARTICIPANTS EXPERIENCED ROLE CONFLICT AT DIFFERENT LEVELS WHILE WORKING IN THE CLINICAL AREA.

The participants stated that they experienced role conflict at different levels while working in the clinical situation. This role confusion conflicted with the expectations of their colleagues and hospital/clinic management. The researcher then identified role conflict related to their own professional role, expectations from colleagues and expectations from management as the sub-theme to this theme.

SUB-THEME: NURSES EXPERIENCED ROLE CONFLICT RELATED TO:

The role conflict that nurses experienced related to their own professional role, expectations from colleagues and expectations from management.

A. Their own professional role
Based on the participants’ account of the behaviour they displayed while in the clinical situation, an impression is created that they were experiencing role conflict within themselves as health professionals and as traditional healers. As an illustration, all the participants stated that while examining the patient they would have that “special feeling” that the patient did not need western medicine or hospitalisation but traditional medicine and would secretly advise the patient accordingly. To quote one of the participants who expressed this sentiment:

“I whisper to the patient in hospital and say ‘go to a certain place.’ I say it secretly.”

A similar experience was expressed by another participant:

“Sometimes as I do physical examination on a patient, I have that feeling in my blood that this person does not need a doctor, he needs a Xhosa ritual. I follow a
person and call him aside and tell him ‘Please, go to your people and ask them to take you to a diviner.’ ”

This was confirming what one participant had commented on when the researcher was conducting the focus group interview with allopathic health practitioners. The participant in the focus group interview had indicated that they ‘did not click’ with nurses who were traditional healers as those nurses had a tendency to mix two things, traditional and western healing, by encouraging hospitalised patients to consult traditional healers.

One participant further stated that she would sing traditional songs and stamp dance while attending a patient if there was an urge to do so. The following statement highlights the experience:

“Sometimes while on duty, something tells me to sing the traditional song that says ‘The voices are coming in the morning’ (oonomathotholo bayeza kusasa). Even if I was taking the patient’s blood pressure, I put down that stethoscope and baumanometer and stamp dance, stamp dance, stamp dance.”

As the participant made this statement she appeared not to realise that there were ethical standards of behaviour that she had to adhere to as laid down by her standard-generating body.

B. Expectations from colleagues

One participant highlighted the fact that as traditional healers they had a tendency not to behave according to the expectations of their colleagues. They sometimes viewed things from a different perspective and became irritable without provocation. Two of the participants stated that there were times at work when they needed to be all by themselves and did not feel like talking to or greeting anybody. Referring to the reaction of colleagues to their “moody spells”, the participants had this to say:
“They used to be fed up, in so much that sometimes on turning my head, I would find them backbiting”. I had to explain that ‘People,” you have to understand that I am sick.’”

“Sometimes you could see that it could make you to be taken in bad light at work. When I am being told things by the ‘voices’ on the roof and I say those things, people say I am a schizophrenia.”

Informal conversation of the researcher with other western-trained health professionals on the issue of nurses who are traditional healers revealed that this cadre of a healer could at times interfere with patient management. A patient being prepared for undergoing an operation in theatre would for instance suddenly change his/her mind and refuse to be operated upon, because he/she had been secretly advised by the nurse who was a traditional healer that his condition did not warrant surgical intervention, but a cultural ritual.

C. Expectations from management

It appeared that sometimes the behaviour of the participants at work was contrary to the expectations of management or authorities. One participant, for instance, narrated an instance about when she was confronted by the doctor while busy stamp dancing. He enquired why she was jiving while he wanted to be assisted with patient examination in the consulting room. She informed the doctor that she would come when that urge to sing had subsided. This is evident in the following statement narrated by the participant:

“The doctor was looking for a nurse to interpret for him. The nurse he had sent found me singing and stamp dancing and patients assisting with singing. The nurse said ‘The doctor is waiting for somebody to assist him.’ I continued to stamp dance until Dr O. came himself and asked ‘Why are you jiving when I am waiting for somebody to assist me?’ and I said ‘Look, doctor, if you can report me to Head Office that I am jiving, I can be expelled. I am not jiving, I am stamp
Two of the participants gave an account of incidents involving their leaving the hospital premises while on duty to attend to an assignment given by the ‘voices’ or to have time to talk with ancestors. These excerpts highlight the participants’ experience:

“Hospital authorities knew that there was something that I did at times, that they could have ‘beaten’ (punished) me for. If ‘something’ says to me ‘go out of that gate and look for So and So in that particular place and attend to him/her,’ I would just take my bag and go out. They would see me going that way.”

Similar behaviour was reported by another participant:

“When somebody annoys me at work, I just go out of that big gate. I use the gate for cars to go and discuss with the ancestors in a secluded place overlooking a cliff or a sea.”

It has to be borne in mind that staff allocation for different shifts in the clinical situation is done by supervisors and approved by management taking into account the balancing of the staff according to seniority and complexity of the procedures and activities to be performed on patients during that particular shift. One would imagine that this sudden disappearance of one staff member could have a destabilising effect on patient care.

No literature could be found that related to role conflict of nurses who were also practising as traditional healers but Mellish and Paton (1999:147) provide professional guidance relating to when social behaviour norms are in conflict with professional values and norms. They advise that in such a situation, professional norms should always be upheld. These authors further assert that the nurse is
accountable to her/his colleagues by maintaining a professional image; to her/his employer by rendering a full day’s work for a full day’s pay and to the doctor and the public by maintaining ethical standards (Mellish & Paton, 1999:154).

3.2.4.2 THEME 2: PARTICIPANTS PERCEIVED THAT THE ACT WOULD CREATE OPPORTUNITIES FOR THEM.

Although two of the participants felt threatened by the Act in case they would be forced to share their information about herbs which they had obtained through listening to their ancestors, all participants including the two, foresaw opportunities for themselves resulting from the implementation of the Act. The aspects that the participants were looking forward to, were those that they thought would benefit them. These related to the recognition that they would enjoy as practitioners in their own right which was indicative of an elevated status and the expansion of their scope of practice. The participants anticipated that after the implementation of the Act, their scope of practice would be expanded. They expected to be consulted by nurses and doctors to give an opinion on the patient’s condition. This would apply particularly to patients who visited the health facilities repeatedly presenting with the same ailment. The objective would be to articulate whether the illness of the patient was of cultural origin or needed the attention of the western medicine. A start on this consultative function had been made by some doctors as was indicated by one participant who was already regarding herself as a consultant in her own right. As she put it:

“For example, at present the doctors call me, not for interpreting for the patient but requesting to know whether the condition of the patient warrants western medical care or has to be handled the Xhosa way.”

Other expected opportunities stated by the participants which would reflect an expansion of their scope of practice, would be handling clients who were covered by the Medical Aid Insurance, issuing sick certificates to their patients and
receiving royalties should their medicinal discoveries enter the market. One of the participants further suggested that a new type of special leave be introduced by the government to cater for them when they had to go and conduct rituals for their clients, like the ritual of keeping a client in a grass seclusion hut which usually took about seven to fourteen days. The current situation is that the nurses who are traditional healers have to resort to utilising their sick leave days when the vacation leave days have been exhausted. This concern was expressed by one participant as highlighted below:

“I must be given leave officially that says, ‘Sister S. is going to conduct a ritual for her trainees.’ I must not lie and say I am sick or have a domestic problem when I am not sick.”

The opportunities that nurses who are traditional healers hoped to enjoy following the implementation of the Act, therefore, related to increased income from Medical Aid Schemes and payment for royalties plus entitlement to a special type of leave of absence from work as well as authority to issue sick leave certificates, to their clients. As another aspect of an extended role for nurses who are traditional healers, one participant advised that these nurses were the ideal calibre to be used to conduct in-service training for traditional healers. They would have to hold workshops to educate traditional healers on issues relating to personal and environmental hygiene, correct use of traditional medicines in terms of the strengths, cleanliness and proper storage as well as moral issues relating to sexuality. Since these nurses had the knowledge of both worlds, the participant felt that these issues would be dealt with tactfully and with sensitivity.

Although she did not elaborate on this issue, Ehlers (2000:31) had also anticipated that the future scope of practice of professional nurses might become influenced in numerous ways should traditional healers obtain statutory recognition.
3.2.4.3 THEME3: PARTICIPANTS ADVOCATED FOR CAPACITY BUILDING OF TRADITIONAL AND ALLOPATHIC HEALTH PRACTITIONERS IN PREPARATION FOR FACILITATING COLLABORATION AND CROSS-REFERRAL OF PATIENTS

Participants felt that there was a need to build the capacity of traditional and allopathic health practitioners as this would facilitate collaboration and cross-referral of patients. A statement from one of the participants reflects this viewpoint:

“We must stop criticising each other. If the two sides can be work-shopped, sit together around the table and share ideas, it can be easy to collaborate and refer a patient. By the way we have different blessings.”

The need for capacity building was alluded to by another participant:

“I am not suggesting that capacity building should only be for traditional healers, but also for nurses and doctors. It will then be possible for the western-trained healer to realise that this condition is beyond me, this patient has been taking these tablets but is not becoming better. Like an adolescent who bleeds excessively during menstruation without stopping, the western-trained doctor will continue to give Ovral 28 with no success, meanwhile the reason is just that she is ‘naked.’ She needs a ritual called ‘imbeleko.’ If these things are ironed out, referral will be possible.”

A remark from another participant was:

“Like in hospital, there are doctors’ rounds and meetings, whether in a paediatric, medical or surgical section where they discuss about patients. Traditional healers could join these meetings, learn about examination procedures and take part in
the discussions, advising doctors especially on patients who have been admitted for a long time."

The view of the nurses who are traditional healers was that capacity building would assist traditional health practitioners to comprehend basic health issues and avoid practices that were harmful to themselves and to their clients. They cited a number of harmful practices that were inflicted by traditional healers while performing certain procedures and treatments on their patients. These were also alluded to by the traditional birth attendants when individual interviews were held with them. Traditional birth attendants stated for instance, that they applied soot taken from the roof of a thatched hut or the excreta of mice, ash or cow dung on the newborn’s umbilicus to dry and heal it. This was mentioned by all three traditional birth attendants who participated in the study. The researcher noted that the methods that the three traditional birth attendants said they were using in managing pregnancy and delivery, were so similar that one would have thought that the participants were taught or trained in the same institution.

These are excerpts from the traditional birth attendants’ experiences:

“When there is something that does not want to come out, we usually take two tablespoons of ash, mix it in warm water, pluck out soot that hangs from the roof of a thatched hut… a hut that is used as a kitchen where we make open fire, add the soot in the mixture, strain it with a clean cloth and give it to the mother to drink.”

“In that baby’s umbilicus, you sprinkle mice excreta, not powder. You grind the mice excreta. We don’t know these powders, net mice excreta. The mice excreta heals, it’s medicinal.”

“For the delayed placenta, we would take that black thing hanging from the roof of a thatched hut that is used for making fire, mix it with water, cook it and give to the mother to assist with the delivery of the placenta.”
Herbalists and some diviners on the other hand had indicated that they changed the blades that they were using for applying their potions on their patients through skin scarification, only when it became blunt. One participant stated that even the very skin lesions were sealed with the healer’s saliva; meanwhile the healer was not even aware of his HIV status. On the other hand some traditional surgeons were still using the same knife in circumcising the boys irrespective of the number of boys to be circumcised. This practice could easily lead to the spread of communicable diseases. These were all the concerns that nurses who are traditional healers felt should be rectified through workshops to build the capacity of traditional healers. An informal conversation held in August 2005 between the researcher and one of the managers responsible for disease surveillance in the provincial office of the Eastern Cape Department of Health revealed that there were still situations where traditional birth attendants in one of the remote areas in the north eastern part of the Province of the Eastern Cape would try to stop bleeding from the newborn’s umbilicus by sucking the umbilicus. The danger of this practice to the healer cannot be overemphasised.

Hillenbrand (2006:13) maintains that educating and training traditional health practitioners can be a valuable instrument in attaining health goals particularly in areas where conventional health facilities and personnel are lacking. She further makes reference to a situation in the Cameroons where exposure to conventional medical care seems to have made urban traditional practitioners more aware of the boundaries of their treatment.

Capacity building posed a challenge as most of the traditional healers were illiterate or poorly educated. Those would then need to first undergo basic education and training. In a study conducted by Sharma and Ross (1990:351), it was indicated that since most women could not read or write, the teaching was based on practical demonstrations, group discussions and pictures which could easily be understood. Steyn and Muller (2000:8) conducted a study to explore the possibility of incorporating traditional healers into the westernised medical
efforts to combat cancer. They highlighted the fact that pictures, pamphlets, magazines and other material that was simple to understand and which would suit the level of education of a healer, be used. The main need was for illustrated pamphlets, brochures and magazines in a black language. Regarding training of traditional surgeons, Mogotlane, Ntlangulela and Ogunbanjo (2004:57) recommended that education programmes for traditional communities be designed by the Department of Health and the Department of Sport, Arts and Culture.

Molepo (2000:61) also supports the need to train traditional practitioners in basic disease prevention. She suggests that traditional healers should be trained to recognise the signs and symptoms of diseases so that they can refer patients to higher healthcare units. They should also be trained in First Aid techniques (Molepo 2000; 62)

Capacity building was also deemed applicable for allopathic health practitioners so as to understand cultural issues relating to health and illness. The inclusion of traditional medicine in the curriculum of both nursing and medical students was suggested by the participants. This is supported by Mulaudzi (2001:18) who recommends that traditional healing be taught in nursing schools, technikons and universities as a field of medicine. Healers from both fields needed to be trained to understand each other’s mode of care.

3.2.5 A SUMMARY OF FINDINGS FROM ALL GROUPS OF PARTICIPANTS
On completion of the focus-group and individual interviews held with allopathic health practitioners (Group 1 & Group 1a) and individual interviews of traditional health practitioners (Group 2) as well as for nurses who were also traditional health practitioners (Group 3), the researcher noted that the participants’ responses to the three research questions that were posed by the researcher, reflected areas of convergence and divergence. All participants, for instance, indicated that there was no formal interaction between traditional and allopathic
health practitioners before legalisation of traditional health practitioners. Their working relationship was characterised by a one-sided informal referral system, with traditional health practitioners referring patients to allopathic health practitioners but this did not seem to be reciprocated. This situation was said to emanate from the negative attitude of allopathic health practitioners toward traditional healing. The negative attitude was perceived to be the result of the problems encountered by allopathic health practitioners which emanated from the practices of traditional health practitioners. Traditional surgeons were the only category of traditional health practitioners who enjoyed mutual referral of patients with allopathic health practitioners. Their working relationship was formalised by the Application of Health Standards in Traditional Circumcision Act, Act No. 6 of 2001. Traditional health practitioners also had a negative attitude, suspecting that the move towards collaboration was a ploy to steal their knowledge of traditional medicines.

When asked about the impact that the new Act would have on their practices, there were divergent and ambivalent views from the participants. Some participants highlighted economic gain, occupational protection and expanded scope of their practice as benefits that they anticipated enjoying, while others expressed concern about threatening factors inherent to the implementation of the Act. The expectation that they would need to divulge information obtained from their ancestors regarding their traditional medicines was most threatening to the traditional health practitioners.

Participants, especially traditional health practitioners, explicitly indicated that their understanding of collaboration was the existence of a reciprocal referral system between allopathic and traditional health practitioners. For them, this was the crux of the matter. An essential element for collaboration was to understand each other and dispel elements of mistrust. Participants suggested that the two healing systems should run parallel to each other but with identified areas of collaboration. Building the capacity of each group by holding meetings together,
conducting workshops, offering training and conducting research were activities that were highlighted as essential for assisting in facilitating collaboration between the two groups of health practitioners.

3.3 CHAPTER SUMMARY

Chapter 3 covered Phase One of the research study. The researcher explored the experiences of traditional and allopathic health practitioners as stakeholders in the healthcare delivery landscape prior to the legalisation of traditional healers, elicited their viewpoints regarding the impact that the new Traditional Health Practitioners Act, Act No. 35 of 2004 would have on their individual practice, and the mechanisms that could be instituted to facilitate collaboration between allopathic and traditional health practitioners to enhance and complement service delivery. Data was obtained from transcribed focus group and individual interviews and modified participant observation. The data was then analysed and themes and sub-themes identified. Findings were presented and discussed making reference to literature available on the topic. The next two chapters will cover Phase Two of the study and will entail the development of strategies to facilitate collaboration between allopathic and traditional health practitioners to optimise and complement healthcare delivery.
CHAPTER 4

DEVELOPMENT OF A CONCEPTUAL FRAMEWORK OF STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

4.1 INTRODUCTION

The previous chapter dealt with the discussion of findings emerging from individual and focus group interviews which were conducted with three groups of participants, namely, allopathic health practitioners, traditional health practitioners and nurses who were also traditional health practitioners. The discussion also integrated findings from a literature control and field notes. The researcher further reflected on critical issues that she had noted during participant observation as she had attended a number of occasions and rituals pertaining to traditional healing. The selected occasions included a cleansing ceremony held at Vlakplaas in Gauteng province in December 2003; the graduation ceremony of a diviner which was held at the Nxuba Local Municipality in Amathole District Municipality on 22 April 2005; a séance held by traditional healers in Buffalo City in December 2005 and a conference on institutionalisation and operationalisation of traditional medicine at Kopanong Conference Centre in Gauteng Province on 9-10 June 2006. All these activities were detailed in chapter 2.

The researcher also participated in a ritual that took place in a relative’s home on 6 October 2006 where twenty-six family members of the same clan were kept for five days in a grass seclusion hut in a quest to attain good health and prosperity. This procedure was followed by a ritual to “bring back home” certain ancestors that were identified by the diviner as being displeased because they had never been “brought back home.” The ritual was conducted by the same diviner who had performed the seclusion ritual. Together with family members, the diviner
travelled with a live goat to the banks of the Great Fish River and a nearby forest/cliff where he called aloud upon all ancestors who had not been “brought back home” to return to the family, and imbue family members with health, wealth, protection and fertility. Attending these occasions assisted the researcher to re-contextualise the study and place certain healing practices of traditional healers into perspective. As the researcher is trained as an allopathic health practitioner, she did not make any special efforts to attend activities conducted by allopathic health practitioners since she is well versed with this field.

Chapter 4 deals with the development of a conceptual framework of strategies to facilitate collaboration between allopathic and traditional health practitioners. Before discussing the conceptual framework, the researcher will sketch the current scenario in the field of traditional healing with the aim of familiarising the reader with the environment in which the proposed strategies will be implemented.

4.2 THE CURRENT SCENARIO

This study was conceptualised in the year 2003 after the Traditional Health Practitioners Bill, dated 12 April 2003, was gazetted. Since then significant on-going changes have occurred in the field of traditional healing at a political level and in the National and Provincial Health Departments. An outline of these changes is presented below.

4.2.1 Policy changes

As was indicated in the previous chapters, legalisation of traditional health practitioners in South Africa materialised after the publication of the Traditional Health Practitioners Act, Act No. 35 of 2004. This Act made provision for the establishment of the Interim Traditional Practitioners Council of South Africa which would regulate the practice of traditional health practitioners. Before full implementation of this Act, one group of stakeholders, called Doctors for Life,
challenged the constitutional validity of the Act in the Constitutional Court of South Africa. Doctors for Life argued that Parliament had failed to fulfill its constitutional obligation to facilitate public involvement before passing the Traditional Health Practitioners Act. Their complaint was confined to the process followed by the National Council of Provinces during the development of the Act (Media Summary, 2006:1). The argument of the Constitutional Court on 17 August 2006 is contained in the Media Summary document entitled CCT 12/05.

Outlining the duty of the National Council of Provinces of facilitating public involvement in the development of an act, the Constitutional Court held that the National Council of Provinces represented the provinces and had to ensure that provincial interests were taken into consideration in the law-making process. Furthermore, Parliament and provincial legislatures have a broad discretion to determine how best to fulfill their constitutional obligation to facilitate public involvement in a given case as long as it is reasonable to do so. This duty requires Parliament and provincial legislatures to provide citizens with a meaningful opportunity to be heard in the making of laws that will govern them (Media Summary, 2006:2). On the question of whether the National Council of Provinces had complied with its duty to facilitate public involvement in relation to the Traditional Health Practitioners Act, Act 35 of 2004, the Constitutional Court found that the Act had generated public interest as evidenced by requests for public hearings. Because of insufficient time, not all provinces held the required hearings on the Traditional Health Practitioners Bill in November 2003 and the attention of the National Council of Provinces was drawn to that fact.

The Constitutional Court held that failure by the National Council of Provinces to hold public hearings in relation to the Traditional Health Practitioners Act was unreasonable. The court concluded that the National Council of Provinces did not comply with its obligation to facilitate public involvement in relation to the Traditional Health Practitioners Act as contemplated in Section 72 (1) (a) of the Constitution. Because of failure to comply with the duty to facilitate public
involvement, the court held that the obligation to facilitate public involvement was a material part of the law-making process. Failure to comply with this constitutional provision rendered the resulting legislation invalid. The court accordingly declared the Traditional Health Practitioners Act invalid, but suspended the order of invalidity for a period of 18 months to enable Parliament to enact this statute afresh in accordance with the provisions of the Constitution (Media Summary, 2006: 3).

Subsequent to this a new Bill, the Traditional Health Practitioners Bill was passed in June 2007 and public hearings were held in various venues in the Eastern Cape. In the Amathole District Municipality, public hearings were held in King William’s Town in August 2007 and the second round of public hearings took place during the month of November 2007 in provinces like Gauteng province but not in the Province of the Eastern Cape. A new act, the Traditional Health Practitioners Act, Act No. 22 of 2007 dated 10 January 2008 was then passed.

4.2.2 Progress made by the National Department of Health on traditional healing

To facilitate operationalisation and institutionalisation of traditional healing in South Africa, the National Department of Health has established a Directorate of Traditional Medicine under the Pharmaceutical Services Cluster to oversee traditional health services in South Africa. The National Department of Health periodically organises workshops and conferences on traditional medicine to create a platform for all stakeholders to discuss issues relating to the traditional healing system. In some of these conferences, delegates from as far away as China, India, Uganda, Zimbabwe and Tanzania attend and share experiences regarding the extent to which the traditional healing system has been integrated/accommodated into the national health system in their countries. Such exposure to national and international experiences affords delegates, especially those from
the Province of the Eastern Cape, an opportunity to learn lessons on utilisation of traditional health services.

The National Department of Health also collaborates with the Medical Research Council by providing funding for research into African traditional medicines that are used in the treatment of diseases such as malaria, high blood pressure, diabetes mellitus, HIV and AIDS and other communicable and non-communicable diseases.

The Department further supports sustainable cultivation of medicinal plants utilised in African traditional medicines through the Innovation Fund Projects that have been allocated to Consortiums consisting of the Council for Scientific and Industrial Research, Agricultural Research Council, Medical Research Council and Universities. All these opportunities and platforms are created by the National Department of Health to engage critical stakeholders in discussions aimed at making traditional healing an understood, recognised, credible and acceptable field of medicine as communities are currently consuming the services of traditional healers.

4.2.3 Progress in the Provincial Department of Health

The progress made by the Department of Health in the Province of the Eastern Cape is the establishment of a Sub-directorate on Traditional Health Services which is located in the Primary Health Care Programmes directorate. The organogram of this unit is as follows:
One of the officials marked with an asterisk in the above organogram is designated as the Provincial Co-ordinator for the affairs of traditional health practitioners in the province. The incumbent is a registered nurse and a fully fledged diviner responsible for overseeing traditional health services in the entire province except circumcision services as she is a female. By virtue of her gender she cannot handle issues pertaining to the circumcision rite, it being taboo in the Xhosa culture for a woman to do so. To the researcher’s knowledge not all provinces have a co-ordinator for traditional health services. In other provinces, traditional health services are being supervised by a programme manager who is responsible for other primary healthcare services who is not necessarily a traditional health practitioner. By having a Provincial Coordinator for provincial health services in the Eastern Cape who is qualified in both fields, there is a foreseeable advantage for implementation of the proposed strategies with reference to buy-in by other colleagues.
After the publication of the Traditional Health Practitioners Act, Act No. 35 of 2004 the Traditional Health Services Sub-directorate started the process of facilitating the registration of traditional health practitioners and establishing provincial and district structures for traditional healers. Meetings were also conducted to inform traditional health practitioners about the Traditional Health Practitioners Act and its requirements. Programme managers in the Primary Health Care Programmes Directorate were assisted in arranging elementary training for traditional healers in the areas of Tuberculosis, HIV and AIDS, Cancer, Sexually transmitted infections and Maternal and Child Health. However, these activities have not been effectively performed as they were all introduced and implemented at the same time with inadequate manpower in the Traditional Health Services Sub-directorate to manage them. In addition, the training that was offered was not based on an actual needs assessment but organised by individual programme managers mainly to strengthen their programmes by using traditional healers as additional human resources.

Having sketched the present scenario regarding traditional healing, the researcher reminds the reader that she seeks to develop strategies to facilitate collaboration between allopathic and traditional health practitioners. The researcher will thus first identify and explore significant concepts in the data derived from individual and focus group interviews which are critical in the development of those strategies.

Data collected from individual and focus group interviews highlighted an area of convergence between allopathic and traditional health practitioners in that both groups of healers aimed at attaining the same goal: that of healing the sick. However, there was divergence in the methods applied in reaching the goal and the divergence emanated from the respective knowledge bases of practitioner groups regarding disease causation and management. This pointed to the fact that among the strategies to be developed, there had to be a strategy that would
address the knowledge gap in relation to health, disease and illness among the
two groups of healers and that strategy had to be informed by the type of
knowing/knowledge that each group lacked. The realization that knowing could
play a significant role in strategy formation – a strategy that had to be based on a
conceptual framework, motivated the researcher to explore the concept of
knowing before discussing the conceptual framework on which the development
of the strategies was based.

4.3 THE CONCEPT OF KNOWING

A concept is defined by Chinn and Kramer (1995:58) as a complex mental
formulation of experience. These authors further state that concepts are both
empirical and abstract. They are empirical because they are formed from
encounters with perceptible reality; and abstract because they are cognitive
representations of what is perceptually experienced.

Chinn and Kramer (1995:2) explain that from the time a person is born, a lifelong
process of learning, experiencing self, experiencing other people and the
environment begins and what people know is the outcome of these everyday
experiences. The processes of knowing in Western academic cultures have been
structured, formalised and systematised. For instance western scientists claim to
know something because they have applied a particular research method or
used a scientific problem-solving approach. In the current study this stance was
predominantly upheld by allopathic health practitioners. The knowledge they had
and the effectiveness of the healing methods they applied had been scientifically
proven within their specific community of practice, but this is not the case among
traditional health practitioners as was explained in chapter 1.

In discussing the concept of knowing, Kerlinger (in Chinn & Kramer, 1995:2)
identifies tenacity, authority and a priori as ways of knowing that is inferior to
science. According to this view, tenacity is the form of knowing in which the
person believes that something is true without reason to question. This type of knowing was observable mostly among diviners in the present study. The knowledge that the diviners used in diagnosing and treating the patients was said to be received from their ancestors through “voices” and dreams and unquestioningly utilised.

Authority is a belief that something is true because an authoritative source or person says it is true. In this study, this way of knowing heralded the practice of traditional birth attendants. Traditional birth attendants had learnt their craft from their mothers, grandmothers, mothers-in-law and other experienced elderly traditional birth attendants in their localities. They administered the traditional medicines learnt from these authoritative persons to women in labour and to newborn babies with confidence. A priori knowing which can also be called deductive reasoning depends on reason and is based on the rationalistic approach which emphasizes the role that reason has to play in the development of knowledge and the discovery of truth.

Carper (in Chinn & Kramer, 1995:4; McKenna, 1997:41) describes four patterns of knowing that nurses (a category of allopathic health practitioners) have valued and used in practice. These are empirics, ethics, aesthetics and personal knowing. Taken together the patterns provide a basis for developing comprehensive knowledge, that is, the wholeness of knowing. Empirics represent knowledge that is obtained by either direct or indirect observation or measurement and that is publicly verifiable, objective, factual and research-based. The quantifiability of empirical data allows objective measurement that yields evidence that can be replicated by multiple observers (McKenna, 1997:41). In this study, it was noted that empirics was the main type of knowing possessed by allopathic health practitioners which guided their practice while traditional health practitioner's knowledge pertaining to diagnosing and treating patients had not been subjected to scientific testing.
Ethics is a moral component of knowing and is concerned with moral duty. According to Carper (in McKenna, 1997:42) ethical knowledge involves the examination and evaluation of what is right and wrong and what are good, valuable and desirable goals. Making ethical judgments often involves confronting conflicting values, norms, interests or principles. Ethical knowledge does not describe or prescribe what a decision should be; but rather provides insight about which choices are possible and why (Chinn & Kramer, 1995:9). Traditional health practitioners were perceived to be lacking in this type of knowing as was pointed out by one of Group 2 participants and illustrated by this excerpt: “let’s agree, there are things that traditional healers have to copy from that side, for instance ethics and the ethical code of conduct.” Such a statement suggests that when developing the proposed strategies, this aspect of ethical knowing has to be incorporated.

Aesthetic knowing is described by Chinn & Kramer (1995:10) as the comprehension of meaning in a singular, particular, subjective expression that is called the art and is made visible through the actions, conduct, attitudes and interactions of the healer in response to others. Aesthetic knowing involves creative processes of engaging, intuiting and envisioning and is not expressed in language but artistically in the moment of action/experience. In the current study sharing of components of skills during the hosting of Open days as will be discussed in chapter 5, will assist in creating insight among allopathic and traditional health practitioners about each other’s practice and treatment modalities thus facilitating effective collaboration between them.

Personal knowing entails self-consciousness about one’s strengths and weaknesses (McKenna, 1997:43). This type of knowing is critical for both allopathic and traditional health practitioners as knowing themselves and their inner resources is important in the construction of therapeutic interpersonal relationship among themselves as practitioners and with the clients. These four patterns of knowing, namely, empirics, ethics, aesthetics and personal knowing,
provide ways for sharing insights and understanding and have to be possessed in totality. In other words a healer should not only possess ethical and empirical knowing but aesthetic and personal knowing as well in order to have a comprehensive understanding of health issues and contribution of other health practitioners.

The researcher would like to reiterate the fact that she has provided this exhaustive discussion of the concept of knowing because of anticipating that the information on knowing could contribute towards strategy development especially a strategy that would address knowledge gaps among allopathic and traditional health practitioners as such a gap could be a prohibiting factor on effective collaboration

As the researcher embarks on the discussion of a conceptual framework on which to base the proposed strategies, she would like to emphasise the fact that her intention is not to develop a specific theory as is applicable with a model or programme development. The researcher will merely craft strategies which have a scientific basis, in other words, the strategies have to be grounded in a theory which will serve as a reference point. The conceptual framework of the strategies will reflect the context in which the strategies will be implemented: a context that is marked by diversity in terms of race, ethnicity and type of healer and is therefore congruent with Leininger’s theory of Cultural Care Diversity and Universality which serves as a theoretical foundation for the entire study as was mentioned in chapter 1.

Having stated that the strategies will be grounded in a theory it is appropriate to recapitulate on what a theory entails. Dickoff et al. (1968:419) define a theory as an invention of concepts in interrelation. Conceptual frameworks on the other hand deal with abstractions (concepts) that are assembled by virtue of their relevance to a common theme. Therefore, both conceptual frameworks and theories use concepts as building blocks.
Dickoff et al. (1968:419) assert that theories may be predictive or prescriptive. Predictive theory is a statement of relations between two states of affairs, a statement that maintains that if the first occurs then the second occurs. This sort of theorising may be useful in developing the proposed strategies in the current study by indicating that if a certain activity is performed to implement a particular strategy, then a particular state of affairs or situation that facilitates collaboration will be produced. Dickoff et al. (1968:419) further state that to announce a prediction requires characterising both the initial and the subsequent state of affairs. An application of this statement to the present study would describe the initial state of affairs as the findings derived from individual and focus group interviews relating to collaboration between allopathic and traditional health practitioners and the subsequent state will be the anticipated outcome regarding collaboration, following implementation of a particular strategy. Such characterisation as elaborated by the authors stated above requires conceptualising the salient or significant factors within the state of affairs, as well as characterising the relations among those factors.

Dickoff et al. (1968: 419) further argue that there could be theories which deal with relations within a state of affairs but which are not merely predictive theories and these might be called theories of promotion or inhibition of occurrence of causal connections. The implication of this argument for the current study is that while implementing the strategies and expecting a particular state of affairs pertaining to collaboration, there could be factors which inhibit the occurrence of the expected collaboration between allopathic and traditional health practitioners and these inhibiting factors may manifest themselves in resistance to change among either allopathic or traditional health practitioners who are the recipients of the strategies. On the other hand, the perception of a strategy as having beneficial elements can be a promotion factor for collaboration.
Having dealt with the predictive theory, Dickoff et al. (1968:420) discuss the second kind of theory, the prescriptive theory, also called a situation-producing or goal-incorporating theory. The prescriptive theory does not just conceptualise factors, factor relations or situation relations but further attempts conceptualisation of desired situations as well as conceptualising the prescription under which an agent or practitioner must act in order to bring about situation of a kind conceived as desirable in the conception of the goal. In the present study this calls for articulation of what the strategy aims at achieving as well as prescription of the procedure, processes or guidelines that have to be followed in implementing the strategy. Dickoff et al. (1968:420) summarise their discussion by stating that theories can be grouped into four levels, namely, factor-isolating theories; factor-relating theories (situation depicting theories), situation-relating theories (predictive or promoting or inhibiting theories) and situation-producing theories (prescriptive theories). Each higher level of theory presupposes the existence of theories at the lower level.

The first level or naming theory is at the factor-isolating level (Dickoff et al., 1968:420). These authors argue that a person cannot conceive or think without words because words are meant to express concepts. The first act of a thinking mind is to create for itself its conceptual ideas. The creation of the cogitation map by the researcher in figure 4.2 depicting concepts that have been assigned names is indicative of that process of a thinking mind. These primitive concepts tend to be ideas the function of which is to allow the mind to point out, denote or attend to conceptually a factor within mind’s consciousness. The verbalisation of these primitive ideas is called naming. The essential function of naming is the giving of a tag to enable reference back to, or communicating about, the factor conceived as having the name assigned (Dickoff et al., 1968: 420). Naming is the verbal counterpart of creating or inventing conceptual unities. Relating the above assertions on naming to the present study, the implication is that the concepts that have been used in the conceptual framework, namely, the agent, recipient,
procedure, terminus and context, have been given these name tags in accordance with the first level or factor isolation theory.

Dickoff et al. (1968: 421) further explain that once factors have been isolated, one moves to the second and third level theories which is seeing things not in isolation but rather in relation. In the current study this would mean for example that there has to be an indication of how the concepts relate to one another, for example how the concept agent relates to recipient. The purpose of the fourth level or situation-producing theory as explained by Dickoff et al. (1968:421) is to allow for the production of situations of a desired kind. The three essential ingredients of a situation-producing theory are:

- goal content specified as aim for the activity;
- prescriptions for activity to realize the goal content and
- a survey list to serve as a supplement to present prescriptions and as preparation for future prescription for activity toward goal-content.

The situation producing theory with the stated ingredients as illustrated above is very appropriate to base the strategies that are going to be described in chapter 5. Guided by this theory, each strategy will outline the goal content specified as the aim of the strategy. The goal content specifies the characteristics of the situations to be produced and serves as a norm or standard by which to evaluate activity (Dickoff et al., 1968:422). The agent responsible for the implementation of the strategies will have to evaluate the effectiveness of the activities by establishing whether or not the activity has succeeded in bringing about the stated goal. The aim of an activity will therefore contribute towards reaching the terminus which is effective collaboration.

The second essential ingredient of a situation-producing theory is conceptualisation of prescriptions to the effect that actions should be taken to realise the goal-content (Dickoff et al., 1968:422). Goal content will not be realised without activity. There has to be a prescription which commands or gives
a directive for acting toward a specified end and the command is directed to some specified agent or agents. In this study, such prescriptions may be in the form of protocols, guidelines, policies and procedures that need to be adhered to by the agent when performing a particular activity to attain the goal content.

A survey list for activity constitutes the third ingredient of a situation-producing theory. Activity has six aspects and those aspects of activity to be highlighted in the survey list are six ways of looking at one thing in the hope of revealing different features as point of view shifts (Dickoff et al., 1968:423). These six aspects are:

(i) Agency: Who or what performs the activity?
(ii) Patiency or recipiency: Who or what is the recipient of the activity?
(iii) Framework: In what context is the activity performed?
(iv) Terminus: What is the end point of the activity?
(v) Procedure: What is the guiding procedure, technique, or protocol of the activity?
(vi) Dynamics: What is the energy source for the activity?

The researcher has chosen the survey list by Dickoff, et al. (1968:423) as the conceptual framework that will guide the development of the strategies for facilitating collaboration between allopathic and traditional health practitioners.

4.4 COGITATION MAP

The researcher’s cogitation map in figure 4.2 depicts the aspects that have been identified by the researcher and classified according to the survey list by Dickoff et al. (1968:423).

Figure 4.2 COGITATION MAP
The aspects that the researcher will focus on in developing the strategies that will facilitate collaboration between allopathic and traditional health practitioners are discussed below.
4.4.1 FRAMEWORK

The framework provides a context in which the activity is performed. The study is conducted within the confines of the Amathole District Municipality, which is one of the seven district municipalities of the Province of the Eastern Cape. This is where the implementation of strategies to facilitate collaboration between allopathic and traditional health practitioners will be piloted. The Amathole District Municipality stretches from the Indian Ocean coastline in the south to the Amathole Mountains in the north and from the Mbhashe river in the east to the Great Fish River in the west. It has a remarkable bio-diversity of rivers, forests, undulating grassland, and waterfalls. The area is 39% urban and 61% rural with a population of 1.7 million. Two-thirds of the district falls under the former Ciskei and Transkei homelands, which is where the lack of basic services such as sanitation, domestic water, access roads and availability of electricity are rife. The problem of informal dwellings (shacks) is prevalent, especially in Buffalo City due to inward migration from the hinterland (Somyo, 2007:8-10).

Health services in the Amathole District Municipality are provided by allopathic health practitioners in one hospital complex (East London Hospital Complex), eleven district hospitals, seven community health centres and two-hundred-and-eight fixed clinics. The vacancy rate in the district hospitals is 67% for medical officers, 13.08% for professional nurses and 38% for pharmacists. In the primary healthcare facilities it is 69% for medical officers, 29.2% for registered nurses and 73.1% for pharmacists (Eastern Cape Department of Health Annual Performance Plan, 2008:138). These figures depict the acute staff shortage that exists especially in the primary healthcare setting. Health practitioners working for non-governmental organisations, other community-based organisations and Local Government are not included in the figures provided. The numbers for traditional health practitioners practicing in this municipality are not reflected as the registration process is not completed yet. In addition to the stated figures one needs to mention that there are other healers whose practice is not monitored but do provide healthcare in the Amathole District Municipality. These include
faith healers and a plethora of herbalists who visit the province from countries like Kenya, Zimbabwe, Mozambique, Swaziland and Lesotho. It should also be noted that the strategies to facilitate collaboration between allopathic and traditional health practitioners will be developed and implemented in a community characterized by cultural diversity as this area is home to the white, coloured, Indian and black racial groups. Blacks residing in this area are predominantly the Xhosas who are the main ethnic group that consume the services of the traditional health practitioners.

4.4.2 THE AGENT

The agent is the individual who executes or facilitates the goal-directed activity. In this case the incumbent will facilitate the process of operationalising the strategies to promote collaboration between allopathic and traditional health practitioners. The agent of change will thus be the General Manager who is in charge of district health services in the Eastern Cape Department of Health. The General Manager can delegate this function to the Senior Manager responsible for community based services down the line to the middle manager for traditional health services until the assignment rests squarely with the assistant manager designated as the Provincial Co-ordinator for traditional health practitioners as reflected in Figure 4.1. Although all four managers have a joint responsibility of ensuring that the strategies are implemented, the General Manager remains ultimately responsible and accountable for the implementation of the collaboration strategies. This manager will present the strategies to his/her colleagues in the provincial office of the Eastern Cape Department of Health and to senior managers responsible for health programmes that utilise traditional health practitioners as additional human resources on an ad hoc basis as surfaced during the interviews. The agent will influence them to become agents of change in their areas of specialisation. It is of utmost importance for this agent to forge links with programme managers responsible for programmes that have been designated as national health priority programmes. These include the
Tuberculosis programme, HIV and AIDS, Maternal, Child and Women’s Health and the Health Promotion programme. This agent will further communicate the strategies to all managers in the primary healthcare setting out there in communities as patients consult traditional health practitioners first before presenting themselves in a clinic, hospital or doctor’s surgery. The agent will also create awareness about the strategies among traditional health practitioners themselves.

Since collaboration between traditional and allopathic health practitioners has never been formalised before, this change may cause suspicion, anxiety and mistrust as surfaced during individual and focus group interviews. This calls for a tactful and empathic approach. The General Manager for district health services will have to assign the Provincial Co-ordinator for traditional health practitioners to organise the launching and roll-out of this collaboration arrangement which will be detailed in chapter five. This agent has to be respectful, with a pleasant disposition and display good communication skills to avoid creating an impression that the healers are being steamrolled into accepting the proposed strategies. The current incumbent of this position is in a vantage situation as she is both a traditional healer and a registered nurse.

As the agent is in a management position, he/she needs to display the capability of performing the four basic managerial functions to implement successfully the strategies for collaboration between traditional and allopathic health practitioners. The managerial functions encompass planning, organising, leading and controlling. Planning involves defining the goals and proposing ways to reach them (Hellriegel, Jackson & Scolum, 1999:10). These goals will relate to the terminus or expected outcomes following implementation of the proposed collaboration strategies. Organising is a process of creating a structure of relationships that will enable the recipients to carry out the planned strategies. This calls for ability to utilise human, material, financial and information resources. This attribute will be critical when the agent makes proposals for the
establishment of district, sub-district and provincial structures of traditional health practitioners. Leading involves communicating with others and motivating them to perform the tasks necessary to achieve the goal (Hellriegel et al., 1999:11). This requires building trust, and operating in an environment of transparency and consultation. As an aspect of control, the agent must solicit feedback to determine the impact of the collaboration strategies on the practice of allopathic and traditional health practitioners and on service delivery.

The internal resources that this agent will need to guide her activities are all the policies, guidelines and operation procedures that are at her disposal as well as the values and ethics that should underpin the strategies. The external resources of this agent are those resources available for maintaining, supporting and protecting the agent’s capacity or power (Dickoff et al., 1968:426). Exposing this agent of change to capacity-building opportunities like attending provincial and national workshops, conferences and meetings will increase her knowledge, skills, confidence and power.

4.4.3 RECIPIENCY

Under a theoretical notion of a recipient of an activity are included all those persons who receive action from agents or who are receptive to activity that has a specified terminus (Dickoff et al., 1968:427). The recipients of the strategies in this study are two groups of health practitioners, namely, Group 1 comprising traditional health practitioners specifically diviners, herbalists, traditional birth attendants and traditional surgeons; and other recipients, Group 2 are health practitioners, the western-trained health practitioners like doctors, pharmacists and nurses working in public and private health institutions and those engaged in private practice. Recipients should have analytical minds as they will in turn be agents of change to their patients, colleagues, communities and community-based organisations.
It was noted in Chapter 3 that some participants/ recipients perceived the new Traditional Health Practitioners Act, Act 35 of 2004 as having beneficial elements to their practice and it can be anticipated that such recipients will readily accept this move for collaboration between allopathic and traditional health practitioners. On the other hand those who felt threatened by the new Act will probably reject or resist the change implicit in the proposed strategies. The agent must therefore be vigilant and sensitive when implementing the proposed collaboration strategies by applying the various change theories and models as elaborated by Reddin, Lewin, Rogers, Havelock and Lippitt (in Swansburg & Swansburg, 1995:250-256). These theories and models will be detailed in chapter 5 when discussing the proposed strategies that will facilitate collaboration.

4.4.4 TERMINUS

The terminus is the end point or accomplishment of the activity (Dickoff et al., 1968: 428). In the present study, the terminus is effective collaboration between allopathic and traditional health practitioners. As was indicated in Chapter 3, when individual interviews were conducted with Group 2 participants (traditional health practitioners), they expressed their interpretation of effective collaboration as meaning the existence of a reciprocal referral system indicating mutual recognition of competence and contribution between allopathic and traditional health practitioners.

Some authors have similar notions about the meaning of effective collaboration. Heinemann and Zeiss (in Posey & Pintz, 2006:373) for instance, explain that collaboration requires interdependence, that is, a reliance on one another in solving a problem or achieving mutual goals. Posey and Pintz (2006:373) also assert that true collaboration goes beyond co-operative activity.

Dickoff et al. (1968:430) advise that an activity’s end point be described fully so that it is easily grasped or easy to communicate. By characterising the terminus
or end point, it will make the activity more attainable or feasible for the agent and more acceptable to the recipient. The issue of acceptability of the activity to the agent or recipients, as highlighted by Dickoff et al. (1968:430), links up with the aspect of dynamics, as acceptability calls for a desire to do or accept as possible power sources for agents and recipients. At the same time if one considers the question of cognitive grasp of the activity, the move is toward the aspect of procedure. The researcher has attempted to make the activity practicable and acceptable for the agents and recipients by describing the aim of the study comprehensively, detailing the activities recommended by each strategy and expected outcomes following implementation of each of the proposed strategies. Whereas each strategy highlights its aim and rationale for implementing, the ultimate goal or terminus of implementing the strategies is to facilitate effective collaboration as reflected by a reciprocal referral system.

4.4.5 PROCEDURE

A procedure is a general rule, the function of which is to offer guides and safeguards with respect to activity (Dickoff et al., 1968:431). The procedure of an activity relates to principles, rules or protocols governing the activity. The aspect of procedure does not stress the outcome or terminus or particularise features of the activity, but rather emphasises the path, steps or pattern according to which the activity is performed (Dickoff et al., 1968:430).

Procedure, as explained by Dickoff et al. (1968:430), may suggest the proper equipment and situation for carrying out activity and may further indicate the danger and success signs that occur in the course of following the procedure. Procedure may propose other activities like reporting or repeating that are appropriate in conjunction with the initiated pattern of activity. The function of a procedure as outlined by Dickoff et al. (1968:430) is to provide sufficient detail to enable an activity to be carried out, to serve as a safeguard to agent or recipient and organisation. A prescribed pattern for arriving at a terminus may safeguard
the agent by providing knowledge thereby decreasing his/her liability to criticism from a recipient or organisation. The recipient and organisation are equally protected at least against certain aspects of an agent’s ignorance. Where danger to the recipient, agent or institution is great, very determinant procedures may be desirable and where peripheral knowledge of a likely agent is somewhat limited, again explicit, rote-like procedures are advisable in order to safeguard performance of the procedure. If potential danger to the recipient is great, procedures should be explicitly detailed irrespective of the richness of knowledge the anticipated agent possesses. As potential danger to the agent, recipient or institution decreases, procedures can leave a greater latitude to the agent. Although there is no potential danger in implementing the proposed strategies the procedure for implementation of the proposed strategies to facilitate collaboration between traditional and allopathic health practitioners will have to be explicit as knowledge about traditional healing in general is minimal.

In the current study, to implement the proposed strategies, the agent will be guided by the Traditional Health Practitioners Act, Act No. 22 of 2007, Application of Health Standards in Traditional Circumcision Act, Act No. 6 of 2001, The Health Act, Act No.61 of 2003, The Constitution of South Africa Act 108 of 1996, The ANC Health Plan and other relevant government strategic imperatives and prescripts.

The agent will have to forge links with the programme manager responsible for policy development to develop relevant policies especially relating to the referral system and policies advocating participation of traditional healers in health governance structures. Regulations, manuals and circulars guiding both the agents and recipients will have to be developed as guiding principles. The responsibility of implementing the strategies requires extensive networking with bodies like the professional councils, associations of traditional health practitioners, traditional leaders, community based organisations, institutions of
higher learning and national and international organisations like the World Health Organisation.

4.4.6 DYNAMICS

In explaining the concept of dynamics, Dickoff et al. (1968:430) assert that the aspect of dynamics of an activity emphasises the power sources for that activity. Power sources can be physical, chemical, biological or psychological. In this study the implementing agent has both physical and psychological power sources. The agent should be energetic, enthusiastic and motivated to have traditional health services established and optimally functional. The agent has the advantage of enjoying a sound working relationship with the National General Secretary of the Traditional Healers Association who is stationed at OR Tambo District Municipality in the Province of the Eastern Cape. This official keeps the agent updated about new initiatives that impact on traditional healing.

Using the conceptual framework for the development of the proposed strategies the researcher would like to mirror the milieu under which the agent responsible for the implementation of these strategies is going to operate in order to reach the intended terminus. This is depicted in Figure 4.3 below.
Figure 4.3 COGITATION MAP ON CONCEPTUAL FRAMEWORK TO FACILITATE COLLABORATION

<table>
<thead>
<tr>
<th>AGENT(S)</th>
<th>RECIPIENTS</th>
</tr>
</thead>
</table>
| General manager: District Health Services  
Senior, Middle and Assistant Managers in the Traditional Health Services Directorate including the Provincial Coordinator for traditional healers | - Traditional health practitioners, namely, traditional birth attendants, traditional surgeons, herbalists and diviners.  
- Allopathic health practitioners particularly doctors, nurses and pharmacists. |

PROCEDURES

Successful collaboration will be done through:

(i) Implementation of the proposed interlinked strategies

(ii) Application of other pieces of legislation, regulations, policies, guidelines and circulars pertaining to traditional healing will assist in maintaining the envisaged collaboration
<table>
<thead>
<tr>
<th>DYNAMICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The strength of the agent lies in his/her ability to adopt a participative approach through involving the people who are going to be affected by the change in the implementation of the strategies.</td>
</tr>
<tr>
<td>Incorporation of a strategy for managing restraining forces like resistance to change will assist successful implementation of the proposed strategies</td>
</tr>
<tr>
<td>Driving forces acting as sources of power for the agent will be the support received from the National and Provincial Department of Health and Chairman for the Provincial Association of Traditional Healers</td>
</tr>
<tr>
<td>Empowerment of the agent through attending workshops and conferences on traditional healing so that she can provide the necessary support, information and facilitation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTEXT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The strategies will be implemented in all five health sub-districts of Amathole District Municipality and at health facilities providing Level 1, 2 and 3 services including psychiatric institutions. Evidence based outcome of this collaboration would be established in designated clinics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TERMINUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective collaboration characterised by reciprocal referral system between allopathic and traditional health practitioners which will complement and enhance service delivery</td>
</tr>
</tbody>
</table>
4.5 CHAPTER SUMMARY

Chapter four described the conceptual framework on which the strategies to facilitate collaboration between allopathic and traditional health practitioners will be based. The survey list proposed by Dickoff et al. (1968:423) was used to guide the discussion of the concepts applicable to the construction of the strategies. The concepts derived from the survey list which included the agent, recipient, context, procedure, dynamics and terminus/outcome were mirrored in a cogitation map. The graphic presentation of these concepts was done to ease the reader's understanding.

In the next chapter, three strategies linked to the findings from the data collection process and based on discussion provided in chapter 4 will be developed and discussed with an indication of the mechanisms to implement the strategies integrated in the discussion. The researcher, however, would like to reiterate that the focus of the study is on the development of the strategies and not on their implementation.
CHAPTER 5

DESCRIPTION OF THE STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

5.1 INTRODUCTION

Chapter four dealt with the development of a conceptual framework on which strategies to facilitate collaboration between allopathic and traditional health practitioners were based. This chapter will cover Phase Two of the study and will describe the strategies for facilitating the envisaged collaboration. The description of the strategies will incorporate proposed techniques for implementation of those strategies.

In the previous chapters there was an indication that allopathic and traditional health practitioners aspired to the same goal: that of healing a patient. However, deducing from the data gathered during the individual and focus group interviews with traditional and allopathic health practitioners, it surfaced that these two groups of health practitioners were not working collaboratively towards attainment of that goal. On the contrary, they stated that they had a negative attitude toward each other. Strategies had thus to be devised to facilitate collaboration between the two groups of healers for the benefit of the patients who use the services of both groups.

The researcher will now provide a comprehensive description of the proposed strategies which are based on the survey list, an ingredient of the situation-producing or goal-incorporating theory that was discussed in Chapter 4. The goal-incorporating theory as was previously highlighted, involves conceptualising the desirable goal content to be attained, prescribing the activities to be undertaken by a specified agent(s) to realise that goal content and outlining the procedures to be followed and protocols to be adhered to by the agent(s)
responsible for implementation of the strategies to attain the goal. This then translates into asserting that the description of the proposed strategies will encapsulate determination of a particular desirable goal or terminus which in this case is establishment of effective collaboration between allopathic and traditional health practitioners concretised by a mutual referral system. The concepts of agent, recipient, procedures, dynamics and terminus that are an integral part of the survey list will serve as cornerstones that guide the implementation of the proposed strategies but implementation of the proposed strategies is not part of this study.

5.2 STRATEGIES TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

The essence of strategy development as upheld by Thompson and Strickland (1998:473) is that it is a process that seeks to challenge assumptions and beliefs, brings about paradigm shifts and creates visions for the future. This statement presupposes that the proposed strategies will produce such a challenge to the assumptions and beliefs of allopathic and traditional health practitioners.

In this study, strategies were devised after analysing information obtained from the participants, taking into consideration the socio-political situation impacting on the traditional healing system. Participants shared their experiences as role-players in the health care delivery landscape in Amathole District Municipality. They also expressed their viewpoints regarding the impact that the new Traditional Health Practitioners Act would have on their respective practices. Furthermore, they highlighted mechanisms that could be instituted to facilitate collaboration between allopathic and traditional health practitioners to complement and enhance service delivery. This information is reflected in the themes that emerged after conducting individual and focus-group interviews. The themes were presented and discussed in Chapter 3 but the researcher will
restate the themes of each group as a reminder and point of departure, followed by a discussion of corresponding strategies to address them.

i) Themes from Group 1 participants: Allopathic Health Practitioners

Theme 1: Allopathic health practitioners reflected on their negative attitude toward traditional health practitioners

Theme 2: Allopathic health practitioners acknowledged that they had a lack of knowledge about the new Traditional Health Practitioners Act

Theme 3: Allopathic health practitioners suggested a need for mutual understanding as crucial to effective collaboration between traditional and allopathic health practitioners

Strategies to address these themes are:

- A strategy to change the negative attitude of allopathic health practitioners
- A communication strategy for dissemination of information relating to the Traditional Health Practitioners Act
- A strategy to instill mutual understanding between allopathic and traditional health practitioners

ii) Themes from Group 2 participants: Traditional health practitioners

Theme 1: Traditional health practitioners experienced a relationship with allopathic health practitioners that was characterized by a one-sided referral system

Theme 2: The new Traditional Health Practitioners Act was perceived by traditional health practitioners as having both beneficial and threatening elements on their practice

Theme 3: Traditional Health Practitioners suggested possible areas of collaboration with allopathic health practitioners
Strategies to address the above themes are:

A strategy to facilitate a working relationship between allopathic and traditional health practitioners that is characterized by a reciprocal referral system

A strategy to eliminate the perceived threatening elements of the Traditional Health Practitioners Act

A communication strategy to reach common understanding and consensus about areas of collaboration between allopathic and traditional health practitioners

iii) Themes from Group 3 participants: Nurses who were traditional health practitioners

Theme 1: Participants experienced role conflict at different levels while working in the clinical areas

Theme 2: Participants had a perception that the Traditional Health Practitioners Act would create opportunities for them

Theme 3: Participants advocated for capacity building of traditional and allopathic health practitioners in preparation for facilitating collaboration and cross referral

Strategies to address the above themes include:

A communication strategy aimed at role clarification and highlighting of unrealistic expectations

A capacity building strategy in preparation for collaboration and cross referral of patients

Analysis, synthesis and cross referencing of the themes and their corresponding strategies by the researcher, culminated in the identification of three strategies that were applicable to all groups of participants and which would facilitate collaboration between allopathic and traditional health practitioners. The researcher coined the three strategies the “Triple C” strategies abbreviated as
“TRIC” strategies. The first “C” of this term stands for “change attitude”, the second for “communication” and the third for “capacity building”. These strategies are interdependent, interrelated and interlinked with the communication strategy playing a pivotal function. As an illustration if an effective communication between traditional and allopathic health practitioners exists and capacity building of both groups is done, this will invariably assist in increasing their understanding of each other’s health practices and changing their negative attitude toward each other. The researcher would like to reiterate the fact that implementing the TRIC strategies will be implementing a strategy to change attitudes, a communication strategy and a capacity building strategy. Each of the proposed three strategies comprising the TRIC strategies are going to be discussed below under the following headings:-

- Summary of findings consistent with the strategy
- Theory informing the strategy
- Aim of the strategy and
- Suggested implementation mechanisms

In addition, the agent of change mentioned in chapter 4 will have to devise a strategy for implementing the three strategies to reach all stakeholders in the healthcare delivery spectrum. After implementing the strategies, it will be advisable for the implementing agent to be vigilant of the strategic drift which Johnson, Scholes and Whittington (2005:27) describe as a situation where strategies progressively fail to address the intended aim.

5.2.1 STRATEGY TO CHANGE THE NEGATIVE ATTITUDE OF ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

Starting with the description of this strategy does not imply that this is the first strategy to be addressed as the TRIC strategies work in unison as an integrated set of strategies rather than in a chronological order.
Summary of findings consistent with the strategy

As discussed in Chapter 3 allopathic and traditional health practitioners participating in the current study verbalised that they had a negative attitude toward each other.

Allopathic health practitioners attributed their negative attitude toward traditional health practitioners as emanating from their encounters with patients who had been mismanaged by traditional health practitioners. Traditional health practitioners for instance were said to be providing patients with unscientific, inappropriate and irrational treatments. They were also said to be interfering with the efficacy of hospital treatments by sneaking traditional medicines for patients admitted in hospital or advising a hospitalized patient to request to be discharged from hospital in order to seek traditional medicine. Allopathic health practitioners also held traditional health practitioners responsible for delaying referring patients to hospitals, clinics and private doctors and only referred them when the condition had deteriorated. Consequently, allopathic health practitioners had to perform extensive medical and surgical interventions to reverse the situation perceived to be caused by traditional health practitioners. This accounted for the negative attitude that they said they held against traditional health practitioners.

Similar concerns were pronounced by the traditional health practitioners who felt that allopathic health practitioners were delaying patients in seeking the services of traditional health practitioners especially patients with diseases of cultural origin and man-made diseases. In addition, traditional health practitioners were negative toward allopathic health practitioners because they did not trust the sudden interest shown by allopathic health practitioners in their practice and suspected that this might be a ploy to steal the information about their herbs and manufacture new medicines in laboratories to sell at a price. A strategy had thus to be developed to address this negative attitude.
**Theory informing the strategy**

Lord (1997:216) and Eagley and Chaiken (in Larson, 2004:167) define an attitude as a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour. A similar view is held by Robbins, Odendaal and Roodt (2003:72) who define an attitude as an evaluative statement either favourable or unfavourable that reflects how one feels about objects, people or events. Lord (1997:216) further mentions a three-component theory of attitudes which describes attitudes as consisting of people’s tendencies toward positive or negative thoughts, feelings and actions. According to Larson (2004:169) this theory is sometimes referred to as the ABC model as it encompasses the following dimensions: affect (A), behaviour (B) and cognition (C). Attitudes are said to have an affective function because they can influence emotions and feelings, a behaviourial dimension as they predispose people to take certain actions as well as a cognitive dimension in that they are learned (Larson, 2004:170). A person’s attitude is therefore a combination of what he/she thinks, how he/she feels and how he/she tends to act (Lord, 1997:216). Attitudes are in part formed, maintained and modified by information about the “attitude object” which can be a person, behaviour or event. Lord (1997:224) illustrates this point by stating that one may have heard remarks about a particular racial or ethnic group and develops a negative attitude before even having an encounter with a member of that group.

It is also upheld that information from the communication media plays a powerful role in shaping positive or negative thoughts about an attitude object (Lord, 1997:224). The power of the media in the current study was observed in the case of traditional birth attendants who had already adopted a negative attitude toward the Traditional Health Practitioners Act, Act No. 35 of 2004 by the time individual interviews were being conducted, participants stated that they were afraid of the Act in case they were arrested for errors in their practice. They quoted information that they had obtained from the radio, television and local newspapers about the number of traditional surgeons alleged to have flouted a
certain Act through mismanaging clients undergoing the circumcision rite. They were apparently making reference to The Application of Health Standards in Traditional Circumcision Act, Act No.6 of 2001.

Adey and Andrew (1990:4) state that attitudes are the result of one’s education, upbringing and culture. This has to be kept in mind by the agent when implementing the three strategies among the two groups of healers (the recipients) as the recipients have different educational backgrounds and are from different cultural settings. Cultural diversity is more pronounced among allopathic health practitioners practicing in the Amathole District Municipality as there are doctors coming from Cuba, Tunisia, Germany, India, and other overseas countries. The diversity is also found among black doctors and nurses as there are those who are from the African states like Kenya, Ghana and Zimbabwe. All have different attitudes toward traditional healers as influenced by their cultural backgrounds.

It is generally argued that unlike personality, attitudes are expected to change as a function of experience and people’s attitudes can be changed by changing their thoughts, feelings and actions (Lord, 1997:269).

**Changing attitudes by changing thoughts**

Lord (1997:269) argues that thoughts about a person, thing or event can be changed by providing new information, new arguments or persuasive communication. This viewpoint is also alluded to by Hovland (Wikipedia: 207) who maintains that attitude change is a response to communication. Following an experimental research that Hovland conducted, he pointed to certain factors that affect the persuasiveness of the message in changing thoughts (Wikipedia:207). These factors are target characteristics, source characteristics and message characteristics. Target characteristics are the characteristics of the person who receives and processes the message. Studies have shown that highly intelligent people and those with high self esteem are less easily persuaded to change their
thoughts by one sided messages. The credibility of the source of the message also influences attitude change. If the source for example is a professional medical journal, one may be more easily persuaded than if it were from a popular newspaper (Lord, 1997:269). Publication of success stories of traditional healers or proof of the efficacy and safety of a traditional medicine used for a particular disease condition in a medical or nursing journal can assist in gradually changing the prevailing negative attitude of allopathic health practitioners toward traditional healers. Source characteristics, where the source happens to be a person, are the expertise, trustworthiness and interpersonal attraction of that individual who is the source of information. The message characteristics refer to the nature of the message and presenting both sides of the story helps change attitude. Lord (1997:253) sums this up by arguing that to predict whether an attitude will change because of persuasive communication, one needs to know who (source) says what (content) and to whom (audience).

The Elaboration Likelihood model, advanced by Petty, Cacioppo and their co-workers (in Michener, Delamater & Myers, 2004:197 & Lord, 1997:263) explains the processes by which messages produce attitude change. These will invariably be processes that will influence the recipients of the TRIC strategies to change their negative attitude. The term elaboration describes the process whereby the target or recipient thinks through the implications of the arguments contained in the message. In elaboration, attitude change occurs only when the arguments are strong or persuasive enough, internally coherent and consistent with known facts. This model as explained by the above authors, presents two basic routes, the central and peripheral routes by which a message may alter the recipient’s existing attitudes.

Foster and Louw-Potgieter (1991:126) uphold that the probability of communication resulting in attitude change is a product of reception and acceptance of the message. When recipients process the message through the central route they spend time and effort on critical evaluation of the content and
issues contained in the message. Attitudes established via the central route therefore tend to be more strongly held, longer lasting and more resistant to change because the recipient has thought through the issue in more detail. Foster and Louw-Potgieter (1991:126) further explain that sometimes people use heuristic or peripheral route processing, for instance making decisions on peripheral factors such as attractiveness or credibility of the source. Attitude change via the peripheral route is therefore likely to be less enduring. This argument presupposes that resistance to change has to be expected from recipients whose negative attitude is central route based. On the other hand recipients who critically evaluate the content of the persuasive communication or explanation of issues given by the agent, and change their attitude accordingly, such change to a positive attitude and willingness to accept, and work collaboratively with each other will last longer than if their attitude was based on heuristic or peripheral route of processing.

**Changing attitude by changing people’s feelings**

Lord (1997:270) states that feelings toward attitude objects are classically conditioned by repeated association of the attitude object with positive or negative events. He further advises that it might be effective to arrange people’s exposure to the attitude object so that it coincides with what we want them to feel. In the current study this approach can be adopted by each group of the health practitioners arranging open days to expose the other group to its healing methods, skills and successes.

- **Changing attitude by changing actions**

According to the Self perception theory (Lord, 1997:295 & Myers, 1993:138) an effective way to change attitudes is to change actions. This theory highlights the fact that people need consistency between their attitudes and their actions. They become upset when they realise that they have one kind of attitude or belief about a person, object or event and yet they have acted as though they had exactly the opposite attitude. This argument is in line with the Cognitive
dissonance theory (Moorhead & Griffin, 1995:62) which upholds that people change their attitudes to reduce the aversive arousal they experience when they have two cognitions or thoughts that contradict each other or are dissonant. Concurring with this notion Lord (1997:277) asserts that one way of changing people’s attitudes is to get them to act in a counter attitudinal way, as though their attitudes were different. This viewpoint is alluded to by Robbins, Odendaal and Roodt (2003:72-73) who point to the research work that revealed that people seek consistency between their attitudes and their behaviour. This means that individuals seek to reconcile divergent attitudes and align their attitudes and behaviour so that they appear rational and consistent. When there are inconsistencies, forces are initiated to return the individual to an equilibrium state in which attitudes and behaviour are again consistent. This can be done by altering either the attitudes or their behaviour or by developing a rationalisation for the discrepancy. The formal working relationship in the Collaboration Clinics recommended in this study may therefore gradually change the negative attitude of the doctor, nurse or pharmacist as they have to engage the referring traditional healers regularly about the outcomes of the referred patients thereby showing recognition of the traditional healer. This inconsistency between their negative attitude and behaviour of recognizing the traditional healer will force them to seek reconciliation of their negative attitude and behaviour of having to communicate with the traditional healers. Lord (1997:275) advises that when trying to change attitudes, it helps to know whether the attitude is based on thoughts or feelings and to tailor the communication intervention to match the type of attitude that has to be changed.

On the other hand, Abelson (in Lord, 1997:269) argues that there are people who retain their original attitudes even if they are presented with what appears to be an undeniable evidence that their opinions are misguided. They use such techniques as denial, bolstering, differentiation and transcendence. Bolstering entails generating new supportive arguments. A person may admit the existence of the evidence, but bolster his/her negative attitude by providing additional
reasons for his attitude or generate new supportive arguments. Differentiation is a strategy in which undeniable evidence is separated into two parts, only one of which contradicts the established attitude. In transcendence people transcend the evidence by inventing a new theory that incorporates both the established attitude and the new evidence. The change agent(s) in particular the Executive manager in charge of the District Health services must therefore incorporate a strategy to deal with resistance to change when implementing the TRIC strategies.

- **Aim of the Strategy**

  The strategy aims at changing the negative attitude that allopathic and traditional health practitioners said they were having against each other. This will invariably dispel the feeling of mistrust and suspicion which were found to be inherent in the negative attitude. McAllister (in Hargie & Dickson, 2004:394) supports the notion that positive relationships cannot be developed or maintained with people one is suspicious or wary of. The strategy thus aims at changing how each group feels and thinks about each other as well as how each group behaves toward each other and this change will be instituted through a process of authentication of traditional healers.

- **Suggested implementation mechanisms**

  The Eastern Cape Department of Health has an obligation to interpret and implement government policies pertaining to health. It then becomes imperative that the department ensures interpretation and implementation of the Traditional Health Practitioners Act, Act 22 of 2007 and foster liaison or collaboration between allopathic and traditional health practitioners. This is in compliance with the requirement for such liaison as outlined in Chapter 2 Section 6(2)(a) of the Traditional Health Practitioners Act, Act 22 of 2007. Such collaboration cannot be successfully established without changing the attitude of both allopathic and traditional health practitioners towards understanding, trusting, accepting and recognising the value that each adds to the health services in the Amathole
District Municipality. Information about allopathic health practitioners is readily available to foster such understanding, stating who they are; what training or professional preparation they have undergone; the treatment modalities they use and where they practice. All aspects of the practice of allopathic health practitioners are therefore known but similar details about traditional health practitioners are not readily available. There is thus a need to authenticate traditional health practitioners in order to obtain the gestalt of their practice. Authentication of traditional health practitioners entails identification of traditional health practitioners through a process of registration; verification process to ensure that they are indeed known as traditional health practitioners by their communities; recognition and accreditation of training institutions for traditional health practitioners; enforcement of record keeping and testing the efficacy and effectiveness of traditional medicines used by traditional health practitioners: These issues are now going to be discussed:

(i) Identification of the traditional healers through a process of registration
Formal registration of traditional health practitioners as required by section of the Traditional Health Practitioners Act will culminate in the establishment of a database of all traditional health practitioners operating in the Amathole District Municipality. The database should reflect:

- the name of the healer
- residential address
- gender
- race
- marital status
- category of the healer
- educational qualification
- training received on traditional healing or nature of preparation for practice and name of the trainer or training school plus the field of training or specialisation of the trainer.
Identifying those with dual roles is important as the researcher, while conducting interviews had noted that some diviners also practiced as herbalists or traditional surgeons in addition to being diviners. On enquiring about this trend, the researcher was informed by the diviners that they were either instructed by their ancestors through dreams to use certain traditional medicines for a particular patient or they learnt about traditional herbs from their spouses or colleagues who happened to be herbalists. The database/registers must be updated annually by each of the five local service areas/health sub-districts comprising the Amathole District Municipality to capture newly qualified traditional healers. The Provincial Coordinator for traditional health services must be assigned to oversee this process and ensure that this statistical information is submitted to the Traditional Health Services Sub-Directorate at Bhisho Head Office for the attention of the Executive manager for district health services. This will also ease the process of registration of traditional health practitioners with the Interim Traditional Health Practitioners Council of South Africa when it becomes operational.

Knowing who the traditional health practitioners are, the nature of training they have gone through and their training schools may increase knowledge and understanding about traditional healers and assist in changing the negative attitude of western trained health practitioners toward traditional healers. In chapter three some of group 1 participants (allopathic health practitioners) mentioned that they could not be expected to work collaboratively with people they did not even know; and establishing this database might help to address that concern.

ii) Verification process
Registration of traditional health practitioners should be followed by a verification process to enhance the credibility of the traditional health practitioners. This is a crucial undertaking as in Chapter 3 the traditional health practitioners who participated in the study expressed concern about the existence of unscrupulous
traditional healers among their ranks. The assistance of ward councillors or traditional leaders (chiefs) must be sought to confirm whether the traditional health practitioner is indeed known, recognized and accepted as such by the local community. These community leaders will be provided with a database of traditional healers practicing in their areas and will be requested to confirm in writing whether the traditional birth attendants, traditional surgeons, diviners and herbalists appearing on the list are indeed credible healers in their communities. The distribution and collection of the lists should be the responsibility of the Provincial Coordinator for Traditional Healers and she will have to compile a database of credible traditional health practitioners from the lists endorsed by the community leaders.

In addition to the above process, further verification can be done by word of mouth by the officials managing traditional health services. Coming from the same cultural background, the researcher also knows that the Xhosas are very vocal about social issues in general, and are equally so about powerful and credible traditional healers and those who are merely opportunists. The researcher also had practical experience about this when she was conducting individual interviews with the traditional health practitioners. She would offer a lift to a person travelling towards the direction of a village, township or informal settlement area where the researcher was having an appointment for an interview. The researcher would deliberately start a conversation relating to traditional healers residing in that area. The passenger would spontaneously mention the reliable, effective healers in that community and how they had acquired their knowledge of traditional healing, tracing it from their forefathers. The passenger would also mention those who exploit traditional healing for financial gains.

An article that recently appeared in the local newspaper, the Sunday Times, confirms the existence of unscrupulous traditional healers. The article narrates an instance where thirteen family members in KwaZulu-Natal died after inhaling
fumes of a concoction of traditional medicines that were burnt by a 16 year old traditional healer who claimed to have trained as a traditional healer in the Province of the Eastern Cape (Sunday Times 2008, 26 September:6). Such communication entrenches the negative attitude of allopathic health practitioners toward traditional healers. The verification process would therefore assist in eliminating unscrupulous traditional healers who tarnish the image of traditional healers, leaving a credible cadre of traditional health practitioners who will be known by the allopathic health practitioners and with whom allopathic health practitioners would probably be willing to collaborate.

(iii) Recognition of training and accreditation of training institutions for traditional health practitioners (amaphehlo)

An exercise needs to be conducted to identify and inspect existing training institutions for traditional healers (amaphehlo) in the Amathole District Municipality. The aim will be to establish the nature of training offered, duration of such training, type of training that the mentor had undertaken, that is, his/her qualifications and the environment under which the training is offered. The results of such inspection should inform the process of accreditation of the training schools by the Interim Traditional Health Practitioners Council of South Africa. The issue of an unhygienic environment in some of the “amaphehlo” was raised by one of the group 3 participants (nurses who are traditional healers) during the interviewing process. She expressed concern with regard to the appalling conditions under which some mentors were operating. The participant was raising this point appealing to the government on behalf of the mentors to provide such needy mentors suitable accommodation. The unhygienic environment under which some traditional health practitioners operated was also raised by allopathic health practitioners during the focus group interview and was highlighted as one of the reasons that made them to have a negative attitude toward traditional healers.
The issue of training received by traditional healers is controversial and is viewed negatively by allopathic health practitioners. The concern is a lack of uniformity regarding the training period. Some take about five years to be fully fledged diviners, while others take about eight months (Daily Dispatch, 2007:28). In the graduation ceremony of a diviner that the researcher had attended, the mentor, while delivering her speech of handing over the trainee to his family, indicated that the trainee was now a fully fledged diviner who had demonstrated a high level of intelligence hence it had taken him less than a year to train as a diviner. The trainee was given an oxtail as proof of having successfully completed training (certification).

Another controversial issue relating to training that the allopathic health practitioners will have to contend with, is the fact that the mentors of the traditional health practitioners, especially of the diviners, are dead (ancestors) or alive persons. Traditional health practitioners assert that they receive information regarding the patient’s diagnosis and treatment from the ancestors. This is an intangible claim that needs to be assessed or verified in concrete terms in order to assist understanding of allopathic health practitioners and to change their negative attitude toward traditional health practitioners and their practice. One way of undertaking this assessment is through an approach that was proposed by two participants who, incidentally, were diviners. This involved subjecting the traditional healer to a form of testing his or her ability and skill to diagnose and treat the patients. Demonstrations to that effect could be conducted. Whereas it can be easy for a traditional birth attendant or traditional surgeon to demonstrate their skill, this may not be the case for diviners and some herbalists. The diviners can, however, be given a number of patients to diagnose and the same patients be asked to consult a western trained doctor to determine whether the two different practitioners arrive at the same diagnosis. Another means of assessment could be to follow up patients who suffer from illnesses that the diviners claim to be able to treat and establish if those patients have indeed been cured by the traditional healers. The two exercises just stated, would be an
attempt to test the proficiency of traditional health practitioners in diagnosing and treating specific conditions. This is also an ideal area for a collaborative research project.

(iv) Testing the efficacy and effectiveness of traditional medicines used by traditional health practitioners

Any traditional medicine that traditional healers claim to be effective in treating a particular illness should be tested in laboratories to confirm their efficacy and isolate any harmful elements that it contains. The Provincial Coordinator for the Traditional Healers should facilitate this process as currently claims of herbalists who can cure certain conditions like HIV and AIDS and cancer are brought to her attention. The testing of these traditional medicines must be controlled by the Eastern Cape Department of Health. The department should sign a Service Level Agreement with local universities that offer the testing facilities/laboratories.

Testing the proficiency of traditional health practitioners in treating certain conditions through the demonstrations elaborated above, would assist the two groups of practitioners to reach consensus on the types of diseases that can be treated by traditional health practitioners. Such tests can be supervised by doctors who are also traditional health practitioners, be conducted in the Laboratory Clinics that will be discussed later in this chapter and accredited by the Interim Council of Traditional Health Practitioners in South Africa. It has to be emphasised to traditional health practitioners that allopathic health practitioners did undergo similar testing for knowledge and skills during their training at universities, technikons, medical and nursing schools and the medicines that they use were also subjected to scientific testing.

(v) Record keeping by traditional health practitioners

Traditional health practitioners should keep a record of patients that they have treated, reflecting the diagnosis and disposal including referrals made to the clinics. Apart from its legality, record keeping will serve as an assessment tool
monitoring the extent of reciprocal referral of patients between allopathic and traditional health practitioners and the level of utilisation of the services of traditional health practitioners. During the interviews participants had indicated that reciprocal referral of patients between allopathic and traditional health practitioners will be indicative of viable collaboration. Group 2 participants (traditional health practitioners) specifically stated that a mutual referral system was their interpretation of collaboration.

Registration of traditional health practitioners reflecting their names and type of healer, followed by the verification process to identify chalartans; recognition of their training, accreditation of their training schools, testing the efficacy and effectiveness of traditional medicines as well as keeping a record of patients consulted, are processes that will assist in increasing the credibility of traditional health practitioners as it will be providing more information about traditional healers which may assist in changing the negative attitude of allopathic health practitioners. It has to be recalled that according to the ABC model of attitude change, providing more information does assist in changing the cognitive element of the attitude. The processes elaborated above will assist allopathic health practitioners to know more about traditional health practitioners, their expertise and any value they add in the provision of health services.

The researcher will now engage in the discussion of the second strategy to facilitate collaboration between traditional and allopathic health practitioners.

5.2.2 THE COMMUNICATION STRATEGY
A communication strategy is a long term plan aimed at addressing the need for effective communication by eliminating communication barriers thereby ensuring free flow of information (Oberholster, 1996:30).
Summary of findings consistent with the strategy

During the interviews it transpired that communication between departmental officials (allopathic health practitioners) allocated to the Traditional Health Services Sub-Directorate with traditional health practitioners was done through meetings but these were exclusively for traditional surgeons to discuss issues pertaining to the circumcision rite. There were no similar communication forums with other types of traditional health practitioners and allopathic health practitioners. Participants further stated in this study that their working relationship was characterized by a one sided referral system with patients being referred by the traditional health practitioners to allopathic health practitioners and never in the reverse. Even then, patients were not formally provided with a referral note and hospitals, clinics or doctors were not phoned in advance to advise them to expect a patient. Patients were merely instructed by the traditional healer to consult a western trained doctor stating that the nature of their illness warranted taking that step.

In spite of the expressed need for communication, some participants, specifically, the diviners felt threatened by the idea of having to communicate to divulge information pertaining to their traditional medicines to allopathic health practitioners. They maintained that they had obtained this information from their ancestors through dreams and “voices” and divulging such information might evoke the wrath of their ancestors.

Theory informing the communication strategy

Fielding (2006:10) defines communication as a transaction whereby participants together create meaning through the exchange of symbols. Four major points are highlighted by this definition, namely, communication as a transaction, people working together, the creation of meaning and the exchange of symbols. Fielding (2006:10) elaborates on this definition by stating that a transaction involves two or more people who construct meaning together. They have to take one another into account and have to work together according to a set of rules. Fielding
(2006:11) argues that people working together have to learn to develop mutual expectations. They need to ensure that others understand what they are trying to say as words do not have meaning in themselves but it is people who attach meaning to words. As the researcher comes from the same socio-cultural background as Group 2 participants, she is aware of certain words pertaining to the diagnosis of patients that are interpreted differently by allopathic and traditional health practitioners as well as by communities. For example, a diagnosis of “food poisoning” given by a western trained health practitioner is in most cases interpreted by some traditional healers and a segment of the community as meaning “having been poisoned with food through witchcraft.” The word “infection” is also subject to different interpretations especially when trying to articulate an exact translation to a Xhosa word. Effective communication therefore demands that people work together to ensure that the meaning created is shared. Fielding (2006:11) stresses the importance of meaning even with non-verbal communication.

A number of authors concur with the importance of sharing meaning in communication judging from their definition of communication. Moorhead & Griffin (1995:352) for example, define communication as a process by which two or more parties exchange information and share meaning. Likewise, Cleary (2003:2) and Tubbs & Moss (1991:6) define communication as the process of creating meaning between two or more people through the expression and interpretation of messages. Cleary (2003:7) further explains that communication is effective when the idea or message as initiated and intended by the sender corresponds closely with the message as it is perceived and responded to by the receiver. He contends that understanding is the result of communication effectiveness. The application of the above statements is very critical for the agents when they implement the strategies.

Elaborating on this concept of meaning, Tubbs and Moss (1991:400) point to the fact that sharing of meaning is more pronounced in intercultural communication.
which is communication between members of different cultures whether in terms of race, ethnicity or socio-economic differences. Intercultural communication has significance in the present study as participants come from different racial groups, have been prepared differently for their practice and also differ in educational background ranging from illiteracy to post graduate levels. The need for sharing of meaning in the present study is evidenced by the statement made by traditional health practitioners when they argued that man-made diseases and diseases of cultural origin would not be known or understood by allopathic health practitioners. The meaning of man-made diseases and diseases of cultural origin will have to be clarified comprehensively considering the aspirations traditional healers have for a reciprocal referral system.

Theorists on communication have isolated key areas in human communication by simplifying the process and representing it in the form of diagrams and models reflecting the sender, the signal or message, and the receiver (Stewart, De Kock, Smit, Sproat & Storrie, 1996:21). According to Fielding (2006:18) communication models can be classified into two main categories: the linear model and a convergence model. The linear model helps to analyse the major elements in the communication process and shows communication as a system which involves an interrelated and interdependent set of elements working together for a specific purpose. The main elements in this model according to Fielding (2006:18) and Dominick (1990:5) are a sender, receiver, message, channel, feedback and the results with psychological and physical noise cited as potential barriers of communication. The sender decides on the purpose of the message, whether it is to inform, persuade or instruct the receiver. The message then has to be encoded in a form that the receiver can understand and sent in a specific format via a channel. The model shows that the message must have a direction. It should be directed at a specific receiver with specific purposes in mind. The sender has a range of codes to choose from, for example, words or non verbal codes and a range of media for example the message can be in a written form and be organized into a format such as a talk, letter, oral or written report.
(Fielding, 2006:18-19). The receiver decodes the message according to his/her knowledge of the subject, ability to use and interpret language and past experience. He/she will make an immediate decision on how to react to the message (Fielding, 2006:19). Effective communication will be reflected by congruence between the message sent and the message received. Linear models of communication focus attention on the sender’s use of messages to influence other people and as such examine one-way communication exclusively (Barker & Gaut, 2002:10). The reader may regard this as an oversimplification of the communication process but the researcher is providing the details to indicate the intricacies that the agents responsible for implementation of these strategies will have to take cognizance of if their aim is to foster understanding and collaboration.

One of the major barriers to effective communication is a different cultural background which may cause a psychological barrier, that is, result in negative attitude because the sender and receiver do not understand each other. The sender may be coming from a specific cultural or work background which means that he/she has a specific language and world view (Fielding, 2006:21). The sender’s work background will give him/her certain experience and ideas on how to do things. The receiver might not have the same culture, language or work background. The attitudes of the senders and receivers are crucial in this case as communication between them will be difficult unless each is sensitive to the other’s situation. Fielding (2006:23) recommends that there should be an arrangement to get feedback which will tell the sender how the receiver has interpreted the message.

The *convergence model* as the second main category of communication theory stresses the transactional and continuing nature of communication. In this model as explained by Fielding (2006:23), the sender and receiver are constantly exchanging messages until they reach an understanding. From a transactional perspective, every communicator is a “speaker/listener” and through that process
of mutual influence, each “constructs” who he/she is and how he/she relates with others -an aspect of personal knowing discussed in Chapter 4. After some time, this interaction will have changed the person for the better (Barker & Gaut, 2002:13). This change in the attitude of a person as the result of effective communication reflects that the TRIC strategy is an integrated strategy.

A number of authors and researchers as will be discussed below present their viewpoints on communication, aligning their arguments with either the linear or convergence models. Steinberg (1995:27) describes Lasswell’s model of communication which emphasises the effect of the message on the recipient. He argues that the communication process can best be explained by asking “who says what, to whom, in what channel, and with what effect?” where, “who” refers to the communicator who formulates the message, “what” is the content of the message, “channel” indicates the medium of transmission, “whom” describes either an individual recipient or audience of mass communication and “effect” is the outcome of the message. He argues that if communication has taken place there must be an effect; the recipient must be persuaded to adopt a particular point of view, in other words there should be an outcome which is what was referred to in chapter 4 as a terminus. For Lasswell, communication is a one way process in which the communicator influences others through the content of the message. It therefore assumes that only the communicator is an active participant in the process and that the recipient plays a passive role. By asking “with what effect?” Lasswell suggests that there could be a variety of outcomes or effects of communication, some of which may be unintentional. This unintended effect was noted in chapter 3 of the present study where one of Group 2 participants complained that they were given so much detailed information about the new Traditional Health Practitioners Act, Act 35 of 2004 that he felt intimidated to accepting everything. He felt so threatened by this detailed information that he was considering abandoning traditional healing.
The Shannon and Weaver Model of communication concentrates on determining the channel that carries the maximum amount of signal or sound, how much of the signal is lost through noise before it reaches its destination and how to eliminate distortion caused by noise (Steinberg, 1995:29). Like Lasswell’s model, Shannon and Weaver's model depicts a sequential process in which each component of the communication process is clearly defined. It also draws the reader’s attention to the effects of noise on the reception and understanding of the message by the recipient. Their concern is the efficient transmission of information from communicator to recipient and the clarity of the message that is transmitted. They do not consider the content of the message or the meaning that is conveyed and interpreted by the participants. Their model is often referred to as the *transmission or technical model* (Steinberg, 1995:30). Theorists who adopt a technical view of communication concentrate on improving the transmission process, that is, the tools and techniques that assist in making communication more effective. A limitation or drawback is that there is no channel for feedback.

Steinberg (1995:31) describes Schramm's three models of communication. His first model is a *technical model* that follows the transmission of a message between communicator and recipient in a linear fashion without paying attention to the content of the message. In his second model Schramm introduced the term “field of experience” which upholds that for a message to be understood by the recipient in the manner intended by the communicator, the participant must share a common language, background and culture (Steinberg, 1995:32). Schramm argues that if people do not have some common background, noise such as internal prejudices may be introduced and cause misunderstanding or different interpretations of the message by the participants. In the third model, Schramm attempts to overcome the problem created by noise by introducing feedback into the communication process to indicate how the message is being interpreted. He regards meaning, not transmission as the most important aspect of the communication process. Schramm and other theorists like Ellis and
McClinton (Steinberg, 1995:33) maintain that even if a message is transmitted and received clearly and accurately, its meaning may not be understood in the same way by the participants, because they may not share similar circumstances or fields of experience. Schramm’s model describes communication as a dynamic interaction in which meaningful messages are exchanged by two active participants. Communicator and recipient both encode, transmit, receive, decode and interpret messages; that is, both play the roles of communicator and recipient. Berlo’s and Prakke’s models (Lowe, 1995:37) provide a broader view of communication by indicating that the communicator and receiver are part of a larger pattern sending and receiving messages in accordance with the expectations and actions of other persons and groups within the same social structure and this group reference may be a positive or negative reinforcement of the messages.

Crafford (in Robbins, Odendaal & Roodt, 2003:225) Fielding (2006:20) and Stewart et al. (1996:24) highlight different cultural backgrounds, use of language that is too technical, illiteracy and defensiveness as barriers to effective communication which have to be taken note of. In the present study, this is extremely important as participants come from different racial groups and use different languages and barriers caused by semantics are inevitable as some words either do not translate between cultures or have different connotations.

The researcher has provided this elaborate discussion on communication because communication is pivotal in facilitating collaboration as it supports other strategies aimed at facilitating collaboration. As an illustration of this point, building capacity of health practitioners and/or communities (the third strategy in TRIC strategies) requires communication and it is also assumed that attitude change is a product of reception and acceptance of the message. This viewpoint is alluded to by Oberholster (in Stewart et al., 1996:30) who believes that free flow communication creates and maintains positive attitudes. The latter reinforces the role of communication in attitude change which is congruent with the view
articulated by Barker and Gaut (2002:18-19) when they describe communication as a biologically and culturally based continuing and interactive process in which people use verbal and non-verbal symbols to shape, reinforce or change one another’s behaviour either immediately or over time for the purpose of satisfying their respective needs and ensuring their survival.

**Aim of the strategy**
The communication strategy aims at disseminating information that will facilitate a process of instilling mutual understanding and collaboration between allopathic and traditional health practitioners. It is a strategy through which other strategies like capacity building and attitude change will be implemented. It will enlighten both groups of practitioners about the Traditional Health Practitioners Act, Act No 22 of 2007 with particular reference to its purpose and requirements and will assist in allaying and dispelling anxieties about the perceived threatening elements of the Act. Group 2 participants in this study had specifically stated that they felt threatened by the Act lest they were coerced to divulge information about their medicines or arrested for errors made in their practice. The communication strategy will also provide an opportunity to reach consensus on areas of collaboration between traditional and allopathic health practitioners. In essence the communication strategy has a clarifying, illuminative, supportive and facilitative function.

**Suggested implementation mechanisms**
The strategy and corresponding implementation mechanisms will be operationalised through meetings, campaigns, radio talks, open days and publications. These mechanisms which are mostly suggestions from the participants themselves are discussed below

**Meetings**
Information obtained from Group 2 participants indicated that ad hoc meetings were convened by the Provincial coordinator for traditional health services to
update traditional healers on policy issues pertaining to traditional medicine that impacted on their practice. Allopathic health practitioners had not been afforded similar opportunities hence those who participated in the focus group interview in this study acknowledged that they had inadequate knowledge about the new Traditional Health Practitioners Act then known as Act No 35 of 2004.

To facilitate collaboration between allopathic and traditional health practitioners, quarterly meetings should be scheduled to be attended by both groups. The meetings must be organized by the Provincial Coordinator and conducted in each of the Local Service Areas/Health Sub-districts in Amathole District Municipality to ensure good attendance by all stakeholders. Initial meetings should provide details about the requirements of the Traditional Health Practitioners Act, which is now Act 22 of 2007 with special reference to the need for liaison between the two groups of practitioners as outlined in Chapter 2, Section 6(2) (a) of the Act. The official(s) from the provincial office must avoid using jargon or too much detail because of the difference in the field of experience between these two groups as was highlighted earlier on in this text. In these meetings both groups have to openly state their strengths and limitations, thus reflecting on their personal knowing, indicate how the practice of each group is creating problems for the other, discuss and reach consensus on the disease conditions that should be treated by each group and articulate their knowledge gaps and training needs. Minutes of the meetings must be circulated to all stakeholders and a record of these minutes be kept by the Provincial Coordinator for Traditional Health Services. Subsequent meetings should be held in the Collaboration Clinics monthly to deal with any emerging issues affecting the practice of both types of healers as will be indicated when discussing the capacity building strategy.

**Campaigns**

Campaigns should be held in each of the five Local Service Areas/Health Sub-districts of the Amathole District Municipality and will serve to not only inform traditional and allopathic health practitioners about the provisions of the new
Traditional Health Practitioners Act, 22 of 2007. Campaigns will also be conducted to create awareness among communities about the standpoint of the government regarding traditional healing. This may result in a positive attitude with communities not hiding the fact that they are taking traditional medicine when they present themselves in hospitals or clinics. The argument by Pinkoane, Greeff and Williams (2005:21) sounds supportive of this intention to campaigns. They argue that simultaneous consultations of traditional and allopathic health practitioners by communities create a problem for both providers and recipients of health care because when complications ensue, one blames the other because of lack of communication between the two systems.

**Radio talks**

An application for a slot can be made to the local radio stations like, “*Umhlobo Wenene*” and Algoa FM to disseminate messages regarding the envisaged collaboration between allopathic and traditional health practitioners. This mass communication will inform the public that traditional health practitioners were now legally recognized by the government and clients should refrain from hiding the fact that they were being treated by a traditional healer when presenting themselves to the clinics, hospitals, and private medical doctors. The disadvantage of mass communication as argued by Dominicks (1990:18) and Fielding (2006:25) is that feedback is delayed. The agent(s) who will be conducting these radio talks will have to arrange phone-in sessions to provide community members an opportunity to seek clarity and debate other issues pertaining to traditional health practitioners. The panel of respondents should comprise managers from the District Health Services Branch in Bhisho Head Office including the Provincial Coordinator plus traditional health practitioners representing the four categories of traditional healers practicing in Amathole District Municipality.
Open days

Arrangements should be made by the Provincial Coordinator for traditional health services with the programme managers responsible for clinic and hospital services in the provincial and district offices to organize open days annually to give the traditional healers an opportunity to tour hospitals, clinics or community health centers that are within their reach. The aim would be to expose them to the machinery or equipment used for diagnosing, treating and rehabilitating patients and the setting or context under which allopathic health practitioners perform their duties. This will be an enlightening experience especially to those traditional health practitioners who wish to be allowed to practice in health facilities. They will see the feasibility of that move and inherent implications for their practice and for the welfare of other patients who do not believe in traditional healing. Stalls manned by doctors, nurses and pharmacists who are experts in their field will need to be organised to give talks on selected diseases especially those prevalent in the area. These talks should be punctuated with touring of the institution and some entertainment. Through such strategies, assimilation of factual health information by traditional health practitioners in a relaxed atmosphere can be enhanced. Lord (1997:270) accentuates the role played by mood in changing people’s attitude. He argues that when people are in a good mood it becomes easier to persuade them to change their attitude than at other times. Similar open days can be organized by the traditional health practitioners where they display their traditional medicines and share information on their use especially the traditional medicines that are commonly used to treat illnesses that are prevalent in that geographical area.

Some participants particularly diviners had expressed reluctance about sharing information in case it displeased their ancestors. The researcher strongly feels that this issue can be negotiated. Diviners can be requested to appeal to their ancestors to allow them to share their knowledge of traditional medicines with other healers for the benefit of the communities. The basis for the researcher’s standpoint is that she observed certain behaviors that were indicative of
modernization that has taken place among traditional healers. As an illustration, in the past, use of mirrors, cellular phones and radios was not be tolerated by traditional health practitioners. Radios were infamous because of the whistling music in some songs which resulted in the traditional healers vigorously shaking their bodies. When the researcher travelled to Vlakplaas with traditional health practitioners to attend a cleansing ceremony as part of participant observation engagement, she noted that a number of traditional healers had cellular telephones. She enquired from a few healers if this was acceptable to their ancestors and the response was that they had specially gone to the cattle kraal (emaxhantini) in their homes to request permission from the ancestors to use the cellular telephones. Their motivation to the ancestors was the distance between them and their patients which necessitated that patients first established if the healer was available at home to avoid travelling long distances in vain. The researcher’s conviction is that a similar request can be made to the ancestors regarding sharing of information about traditional medicines with other health workers be it other traditional healers or western trained health practitioners for the benefit of the clients.

Publications
During the interviews a number of traditional healers had claimed ability to treat certain diseases using their traditional medicines. Such claims need to be pursued and if the efficacy and safety of the medicine is proved scientifically through clinical research, such information should be shared through publication in national and international journals, acknowledging the traditional healer who provided the information. The researcher knows of few traditional healers in Amathole District Municipality who are known to excel in treating infertility and others who are called in cases of delayed labour to induce labour, but because this information is not documented, it cannot be shared.
5.2.3 THE CAPACITY BUILDING STRATEGY

The capacity building strategy offers an ideal situation that reflects that the three strategies cannot operate in isolation. For instance when building capacity one has to use communication and the impact of capacity building is a change in understanding, behaviour and attitude.

Summary of findings consistent with the strategy
The need for capacity building for both traditional and allopathic health practitioners was highlighted by most participants although the focus was mainly on building the capacity of traditional health practitioners. Informal conversation between the researcher and some line managers in the Eastern Cape Department of Health revealed that traditional healers were being used to assist mostly in the management of priority programmes with elementary information provided to help them understand the basics of what they would be assisting with. The priority programmes concerned were the Tuberculosis (TB) programme, HIV and AIDS programme and Maternal, Child and Women`s Health programme. Their participation was, however, not well organized.

Theory informing the strategy
Capacity building can be defined as activities which strengthen the knowledge, abilities, skills and behavior of individuals and improve constitutional structures and processes such that the organization can efficiently meet its mission and goal in a sustainable way (WCO in Wikipedia, 2007:2).

An elaboration of this definition is that capacity building encompasses:-

- Human resource development, the process of equipping individuals with the understanding, skills and access to information and knowledge that enables them to perform efficiently.
- Organizational development, which entails elaboration of management structures, processes and procedures not only within organizations, but the
management of relationships between the different organizations, public and private structures.

- Institutional and legal framework development; making legal and regulatory changes to enable organizations and institutions at all levels and in all sectors to enhance their capacities.

Capacity building will assist each group of healers to learn something new; and learning as described by Argyris (in Thompson & Strickland, 1996: 471) involves uncovering and challenging the assumptions and beliefs that have been formed and reinforced through prior learning. Some of the areas suggested by Plummer (2002:53) that need to be addressed by a capacity building strategy which are relevant in the current study are confidence building, literacy, including legal literacy and technical skills for service delivery. Capacity building of traditional healers in particular is an appropriate undertaking in the current study as the Amathole District municipality has a shortage of western trained personnel as was stated in Chapter 4. Traditional healers thus have a vital role to play in healthcare delivery in the Eastern Cape.

Steyn and Muller (2007:8) conducted a study to explore the possibility of incorporating traditional healers into the westernised medical efforts to combat cancer. They highlighted that pictures, pamphlets, magazines and other material that are simple to understand and suit the levels of education of healers, be used to capacitate them. Molepo (2006:61) also supports the need to train traditional health practitioners in basic disease prevention. She suggests that traditional healers should be trained to recognize the signs and symptoms so that they can appropriately refer patients to higher health care units.

**Aim of the Strategy**

The strategy aims at articulating and addressing the knowledge gaps of both allopathic and traditional health practitioners. Traditional healers should be empowered with basic scientific knowledge and skills pertaining to disease
conditions that are prevalent in the Amathole District Municipality. In addition, attention will be paid to areas of need for capacity as highlighted by the healers themselves in Chapter 3. This included equipping them with knowledge and skills on how to measure their traditional medicines correctly when dispensing to their patients. The strategy also aims at honing their skills in conducting deliveries and circumcision and paying attention to personal and environmental health issues. This empirical knowledge will assist them in making referrals of patients to allopathic health practitioners appropriately thus collaborating in an effective manner.

Capacity building will further assist traditional health practitioners to avoid health practices that are harmful to themselves and to their clients. This strategy will also address an issue which was identified by the researcher among traditional healers especially diviners and herbalists which pointed to a limitation in knowing the ethical issues (ethical knowing). Some healers were using the positions or social status of their clients as a marketing strategy to attract more patients to their services by mentioning prominent figures in the society who had been successfully treated by him/her from a particular illness. These utterances were made without realising that they were breaching confidentiality. For allopathic health practitioners, capacity building will assist in making them sensitive to cultural issues and to better understand illnesses that traditional health practitioners attest to be emanating from failing to observe cultural practices.

**Suggested implementation mechanism**

Implementation of the capacity building strategy can be done through participation of traditional healers in governance structures, establishing joint ventures and inclusion of traditional healing in the curriculum of allopathic health practitioners.
(i) **Participation of traditional healers in Governance Structures**

Inclusion of traditional health practitioners as critical stakeholders in governance structures of the Eastern Cape Department of Health, namely, the District Health Planning Advisory Council, Hospital Boards and Clinic Committees will expose them to the processes of planning and monitoring health services. This exposure will make them more informed and build their capacity and understanding of health issues including legal control of health service provision. They will realise that the very structures stated above have been constituted in compliance to the requirements of an Act, namely, the National Health Act, No. 61 of 2003. Although there will be only a few traditional healers participating in these structures they will be able to share the knowledge and experiences with other traditional healers in their local structures or associations as there is a Provincial Association of Traditional Healers and similar structures at district and sub-district levels. On the other hand such involvement of traditional healers in governance structures may assist in changing the attitude of allopathic health practitioners as they will be compelled to recognise traditional healers as colleagues and critical stakeholders who have to participate in the planning and monitoring of health services.

(ii) **Establishing joint ventures**

Capacity building can be fostered by establishing joint ventures that will provide opportunities for both groups to work closer to each other and learn from such exposure. The envisaged joint ventures will focus on reducing illiteracy among traditional health practitioners; developing the capacity of traditional healers in the area of research; and facilitating provision of effective and efficient health care.

- **Improving literacy among traditional healers**

A challenge facing the Amathole District Municipality relating to capacity building is that most traditional healers are illiterate or poorly educated necessitating that they be given an opportunity to attend Adult Basic Education and Training
programmes as an initial step towards collaboration. Table 3.3 in Chapter 3 on the profile of traditional health practitioners who participated in this study confirms the existence of illiterate to poorly educated traditional health practitioners as it depicts a picture of the level of education of traditional birth attendants as ranging from being illiterate to grade 6 and herbalists from illiteracy to grade 8. The issue of illiteracy among traditional healers was also highlighted by Group 2 participants during interviews. A data base of all healers who will require this training must be compiled and in the spirit of functional integration of services, a concept to which all government departments subscribe, a formal request will have to be submitted by the Eastern Cape Department of Health to the Department of Education to provide this Adult Basic Education and Training. Basic literacy will enable the traditional healers particularly the herbalists and diviners to identify their medicines by labeling them clearly when storing and dispensing them instead of relying on their memory to recognise the medicine. In most cases a patient is given more than one type of medicine and these need proper labelling. An illiterate healer has to rely on his/her children, spouse or somebody else to do the labelling, an action that is subject to errors. Improving literacy of traditional health practitioners will also assist with record-keeping. While conducting individual interviews among traditional health practitioners, the researcher also noted with concern that some of the traditional medicines especially pieces of bark and roots were displayed on the floor unlabelled, had accumulated a substantial layer of dust and had dried beyond recognition. Although not labeling the traditional medicines cannot be fully attributed to not being able to write, the possibility of that being the reason cannot be ruled out.

- **Developing capacity of traditional healers in the area of research**
Participants in this study verbalised the need to be capacitated in the area of research. The Province of the Eastern Cape has three universities offering training for health workers particularly, doctors, nurses and pharmacists. The Eastern Cape Department of Health can establish joint ventures with pharmacology departments in these institutions and Provincial Association of
Traditional Healers so that traditional medicines used by traditional surgeons like “izichwe” to promote healing and drying of the circumcision wound; the labour-inducing “imbeleksane” used by the traditional birth attendants in cases of delayed labour and the whole range of traditional medicines commonly used by the herbalists in treating a variety of illnesses can be tested by the scientists for efficacy and harmful elements. A conscious effort must be made to build the capacity of traditional health practitioners in the area of research (collaborative research) by allowing them to be present and participate when tests are conducted on their traditional medicines either by the local universities or any other university and research bodies like the Medical Research Council, Health Systems Trust or Human Sciences Research Council. The support provided by the universities should not be confined to clinical trials but the three universities together with the Eastern Cape Department of Health Research Unit constituting the Provincial Research Committee should liaise with the Provincial Association of Traditional Healers to request representation of this Association in the Provincial Research Committee so as to participate in all activities of this Committee including hosting the Annual Research Conference. In order to further build the capacity of traditional healers, it is critical that they be given feedback on the findings of any research conducted on their traditional medicines, their healing methods and processes so that they begin to appreciate the benefit of research in their practice.

Traditional health practitioners can also be requested to highlight areas in their field that they feel should be researched whether it pertains to circumcision, traditional birth, divination or herbalism. Traditional healers can be requested to present papers or case studies at conferences, workshops and seminars about any subject relating to traditional healing which will promote better understanding of this field by allopathic health practitioners. The current situation of non-involvement of traditional health practitioners in research activities has resulted in feelings of mistrust particularly around the issue of intellectual property. This suspicion and mistrust of scientists and researchers was also raised by traditional
healers in the conference attended by the researcher at Kopanong Conference Center in June 2006.

- **Partnership aimed at providing effective and efficient health care**

  A policy to entrench a partnership in the form of a formal working relationship can be established by designating certain clinics as Collaboration Clinics in each health sub-district in the Amathole District Municipality with the aim of empowering both traditional and allopathic health practitioners to optimize service delivery. Traditional health practitioners residing in a particular health sub-district should be advised to use the designated Collaboration Clinics as referral points for patients needing the attention of western trained health practitioners. The referring traditional healer must provide the patient with a referral note which should be designed by the Eastern Cape Department of Health. Back referral to the traditional healer should be made by the doctor or nurse working in the Collaboration Clinic to inform the traditional health practitioner about the nature of the intervention made to the patient that he/she had referred. If the patient needed extensive medical or surgical intervention as a result of mismanagement by the traditional healer, sensitive feedback to the healer should be provided to avoid repetition of that action. A record of all patients referred to the Collaboration Clinic has to be kept by both the traditional health practitioner and the clinic nurses to assess the extent of this collaboration.

  Monthly meetings should be held in the Collaboration Clinics to discuss the causes, signs and symptoms, treatment and outcomes of patients referred in that particular month thereby sharing empirical knowledge. This means that all traditional birth attendants, traditional surgeons, herbalists and diviners residing in that health sub-district will have to attend monthly meetings which have to be convened by the Provincial Coordinator for Traditional Healers in the Collaboration clinics. In so doing the traditional health practitioners will get used to certain symptoms that lead the doctors and nurses to arrive at a diagnosis or decide to undertake particular investigation procedures and treatment modalities.
Such exposure will not benefit traditional health practitioners to gain empirical knowing only but to comprehend the art of healing as practiced by western trained health practitioners, thus also gaining aesthetic knowledge. The issue of confidentiality which will equip them with ethical knowing will form part of this exposure. Establishing this formal working relationship in the Collaboration Clinics will therefore provide an ideal situation to provide both traditional and allopathic health practitioners with the wholeness of knowing as was presented in the previous chapter.

In chapter 3 it was indicated that referrals were made by traditional health practitioners to any western trained doctor; but the proposed arrangement of having Collaboration Clinics will make it possible for the healers on both sides to freely interact with one another in a more formalised manner. Allopathic health practitioners will be able to note the symptoms that lead traditional health practitioners to believe that a particular condition is culture related, man-made or natural. In the process they will be gaining insight on the art of doing things from the perspective of the traditional healers and this exercise will equip them with aesthetic knowing as well. This mutual exchange of knowledge will gradually narrow the knowledge gap and facilitate understanding of each other. This is an ideal platform for implementing the three strategies to foster collaboration between allopathic and traditional health practitioners. The platform allows effective communication to take place, capacity building to occur and creates a milieu for possible change of attitude.

The designation of certain clinics as Collaboration Clinics whose referral pattern will be aligned to the Provincial Referral Policy can be piloted in one health sub-district in the Amathole District Municipality and if found to be effective, rolled out to other health sub-districts. The referral policy requires that patients be seen in the clinic first and if there is a need for further treatment, be referred to a community health centre or district hospital (Level 1 hospital) and from there to a tertiary or specialist hospital. As there are already clinics that have been
designated as Centers of Excellence by the Eastern Cape Department of Health, it would be ideal if the Collaboration Clinics are selected from those if possible. Doctors and nurses in these clinics will not be referring their patients to traditional healers as this will be contrary to their ethical conduct, but they will engage traditional healers by providing feedback and further education on referred patients. Allopathic health practitioners will also gain insight as to why some of their in-patients sometimes request to be released from hospital in the middle of their treatment to go home for a few days to conduct rituals aimed at restoring their health.

- **Inclusion of traditional healing in the curriculum of allopathic health practitioners**

  The involvement of the Standards Generating Councils that control the practice of allopathic health practitioners was suggested by some participants in Chapter 3 as a mechanism of fostering collaboration between allopathic and traditional health practitioners. These Councils have to ensure inclusion of indigenous knowledge systems inclusive of traditional healing in the curriculum for the training of doctors, nurses and pharmacists. It is advisable that existing programmes, if there are any, be appraised so that a standard curriculum is developed for the different groups of allopathic health practitioners. With the prevailing emphasis on community based education, the practical aspect of the curriculum must include visits to diviners’ homes to observe healing rituals that they conduct and see their “amaphehlo” (training schools) and “umrawule” (dispensary) and visits to herbalists and traditional birth attendants to observe their healing practices. According to the Xhosa culture females cannot visit the initiation schools and training female students will therefore not be afforded the opportunity of visiting initiation schools to observe health issues relating to circumcision but male student nurses from other cultures can visit the initiation schools. The reader will recall that in Chapter 1 the researcher did indicate that this study was based on Leininger’s theory of Culture Care Diversity and Universality and therefore cultural issues have been central to the strategies
recommended by the researcher. Having discussed the three TRIC strategies that will facilitate collaboration between allopathic and traditional health practitioners, the researcher would like to provide a synopsis of the proposed strategies.
Figure 5.1: SUMMARY OF THE STRATEGIES DEVELOPED TO FACILITATE COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

<table>
<thead>
<tr>
<th>SUMMARY OF FINDINGS</th>
<th>STRATEGIES</th>
<th>AIM</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The working relationship between allopathic and traditional health practitioners was characterized by a negative attitude toward each other and a one-sided referral system</td>
<td>A strategy to change attitude</td>
<td>To change the feelings, thoughts and behaviour associated with suspicion and mistrust inherent in the negative attitude that each group of health practitioners had toward each other</td>
<td>To instill mutual understanding, respect and acceptance which will assist in changing the attitude</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Authenticate traditional health practitioners through registration, verification process, recognition and accreditation of training institutions for traditional healers, testing the efficacy of traditional medicines used by traditional healers and keeping a record of patients consulted by traditional health practitioners in order to make them a credible cadre of healers</td>
</tr>
<tr>
<td>SUMMARY OF FINDINGS</td>
<td>STRATEGIES</td>
<td>AIM</td>
<td>RATIONALE</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>-----</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| - There were no communication forums between traditional and allopathic health practitioners except between allopathic health practitioners and traditional surgeons - the working relationship between the two groups of healers was characterized by a one sided referral system | Communication Strategy | Disseminate information relating to the requirements of the Traditional Health Practitioners and the TRIC strategies | Provide information to dispel the threatening elements of the Act, clarify roles and eliminate unrealistic expectations | - Conducting meetings  
| | | | | - Disseminate information regarding the proposed collaboration between allopathic and traditional health practitioners through:  
| | | | | - Radio talks,  
| | | | | - conducting campaigns and stakeholder imbizos  
| | | | | - Hosting of Open Days by both traditional and allopathic health practitioners  
<p>| | | | | - Sharing information through Publications in professional journals |</p>
<table>
<thead>
<tr>
<th>SUMMARY OF FINDINGS</th>
<th>STRATEGIES</th>
<th>AIM</th>
<th>RATIONALE</th>
<th>SUGGESTED IMPLEMENTATION MECHANISMS</th>
</tr>
</thead>
</table>
| There was a need for capacity building to facilitate mutual understanding and articulation of areas of collaboration | Capacity building strategy had to be developed | To articulate and address knowledge gaps and avoid health practices which were harmful to healers and their clients | To instill mutual understanding of each other’s field, reach consensus on areas of collaboration thereby facilitating reciprocal referral system | - Inclusion of traditional health practitioners in Governance Structures  
- Establishing joint ventures aimed at reducing illiteracy among traditional healers, developing their capacity in areas of research and in technical skills through workshops and conferences  
- Inclusion of traditional healing in the curriculum of allopathic health practitioners |
Having discussed and summarized the strategies that aim at facilitating collaboration between allopathic and traditional health practitioners, the researcher would like to highlight the role of the agent who will ensure implementation of the TRIC strategies.

5.3 THE ROLE OF THE AGENT RESPONSIBLE FOR IMPLEMENTATION OF THE STRATEGIES

Implementing the TRIC strategies is bringing about change and the agent reflected in the cogitation map in chapter 4 will be viewed as a change agent as he/she will be bringing something new in the health service arena in Amathole District Municipality. Smit and Morgan (1996:305) define a change agent as an individual who specialises in facilitating the change during which process new values, attitudes and behaviour are fostered. The researcher feels that this agent should portray the following roles:

- an organizing role reflected in his/her ability to convene meetings and arrange workshops and training sessions where allopathic and traditional health practitioners will discuss issues of mutual interest and be capacitated according to their training needs. Such sessions will assist them to understand each other and eventually recognise the value added by each healer on the public health system. The organizing role also includes the ability to motivate for adequate resources, namely, adequate staff, budget and equipment including transport to manage the traditional health services in the Amathole Health District effectively and efficiently. Whenever a provincial or national event on traditional healing is to be hosted, the change agent has to play a leading role in making logistical arrangements for the occasion and must also assist the relevant groups of healers in the process of selecting the delegates to attend the occasion.

- an articulative role which will enable him/her to articulate the knowledge gaps among members of both groups of healers and to focus on issues and activities that promote collaboration between the two groups.
- a facilitative role which will be displayed through the ability to network. Networking is the process of developing internal and external contacts for the purpose of sharing information, advice and support (Barker & Gaut, 2002:186). The agent will have to network with colleagues responsible for managing traditional health services in other provinces and with traditional leaders whose salutary names should be known and used by the change agent. This role also entails approaching universities, national and international research units and Non-Governmental Organisations to access information on previous research work done on collaboration between western trained and traditional healers elsewhere in the world as well as training programmes and activities that had brought positive outcomes in respect to collaboration.

- a supportive role which has to be provided throughout the phase of implementing the TRIC strategies. This role will incorporate interpreting; clarifying and addressing all concerns of both groups of healers regarding collaboration issues and this may lead to establishing a trusting relationship between the agent (s) and recipients.

The competencies that will enable the change agent to fulfill these roles are sound interpersonal skills, negotiation and teambuilding capability, enthusiasm, political awareness and ability to take a helicopter view to maintain objectivity when addressing matters pertaining to the proposed collaboration.

The initial task that has to be performed by the change agent is to develop an Implementation Strategy which will guide the implementation of the TRIC strategies. Although the implementation does not form part of this study it would be advisable that this strategy ensures that:

- the TRIC strategies are aligned to the vision, mission, strategic goals and objectives of the Eastern Cape Department of Health as contained in the Department’s five year Strategic Plan, three year Annual
Performance Plan and one year Operational or Business Plan. This translates to proposing that the three strategies comprising the TRIC strategies have to be reflected as programme objectives of the Traditional Health Services programme in the three planning documents just mentioned;

- the targets to be achieved in implementing the TRIC strategies have been set, performance indicators articulated and timeframes for attainment of the targets outlined. Persons responsible for carrying out the activities of the TRIC strategies must also be reflected in the Operational Plan;

- resources such as budget and personnel need to be provided and allocated to each strategy in order to attain the goal;

- monitoring mechanisms are incorporated to guard against the strategic drift. Monitoring can be in the form of quarterly, ad hoc and annual reports which will reflect the extent of success of collaboration endeavours in this district municipality. Consumer satisfaction surveys can be conducted to determine the impact of this collaboration between the two groups of healers on the practice of each group of healers and on service delivery;

- the TRIC strategies contribute to the Eastern Cape Department of Health Strategic Imperatives especially in relation to making health services accessible, preventing diseases, promoting health and above all restoring the credibility of the public health system through effective communication of real progress, successes and challenges still to be overcome;

- stakeholder involvement is outlined. This will then need incorporating a marketing strategy for marketing the implementation of the TRIC strategies. This can be done through sourcing the assistance and expertise of other line managers like managers for communication services, managers for events management, health promotion and marketing services;
that the collaborative working arrangement is sustained by institutionalising it through policies and circulars as well as implementing regulations and guidelines regarding traditional medicine issued by the National Department of Health.

The agent has to be mindful that implementing any strategy often involves change (Johnson et al., 2005:19) and change may meet with resistance. According to Barron (in Smit & Morgan, 1996:311) people develop resistance to change if they do not understand the need for change, have not played any part in the initiation of that change or there is a lack of comprehensive information about the change. However, the author further states that change that implies a tangible personal benefit is usually acceptable. In this study some Group 2 participants (traditional health practitioners) expressed mixed feelings about the impact of the new Traditional Health Practitioners Act on their practice. They perceived it as having both beneficial and threatening elements. One can therefore assume that those who foresaw benefits from the Act would be willing to accept the change brought by the Act than those who perceived it as threatening. The assertion by Smit and Morgan (1996:310) also needs to be noted that people adapt more quickly to physical requirements of a change than when a mindset or paradigm shift is required to execute the change.

A number of theorists like Reddin, Spradley, Havelock, Lewin and Ackoff (in Swansburg & Swansburg, 1995:250-253) and authors like Senior (1997:229-233) and Smit & Morgan (1996:305-313) have identified various steps, processes, strategies, theories and models to be adopted in managing resistance to change. The change agent would need to be conversant with and able to use aspects of the authors' arguments, assertions and suggestions when implementing the TRIC strategies. Senior (1997:233) advises that in effecting a planned change all people concerned have to be involved and responsibilities allocated accordingly. As change involves people it becomes imperative to elicit their commitment to the process of change and such involvement will cause them to feel that they have a
vested interest in the change and will make a concerted effort to ensure its success. The participative approach to change has been acknowledged as the best method of averting resistance to change. This notion is reaffirmed by Kotter and Schlesinger (in Smit and Morgan, 1996:313) who suggest that involvement and participation of people who are going to be affected by the change in its implementation; educating them to commit themselves to change; providing support, information and facilitation; using manipulation, implicit and explicit coercion and negotiation is essential in managing change. Consultation is also in line with the ethos of democracy and rights based ideology which are underpinning principles of current government policy.

Reddin (in Swansburg & Swansburg, 1995:250) in his theory for change argues that change is more successful when supported by a group rather than a single person. In the present study joint implementation of the proposed strategies by line managers for district health services and/or by the leadership in the Provincial Association of Traditional healers will have more impact than when implementation of the TRIC strategies is left to be the sole responsibility of one agent, namely, the Provincial Coordinator for the Traditional healers. Similarly, working with groups of healers would be beneficial and this needs a skilled group facilitator who would be able to deal with strong emotions and possible negative attitudes in the initial stages. The value of a force field analysis by stakeholders to identify what they perceive as their own barrier should not be overlooked. Some of the success factors in implementing change that are highlighted by Roger (in Swansburg & Swansburg, 1995: 251) are that change must have relative advantage of being better than existing methods, must be compatible with existing values and be divisible, that is, it must be introduced in a small scale. Lewin (in Swansburg & Swansburg, 1995:251) in his three staged theory on change points to the forces that facilitate the change called driving forces and those that impede it, the restraining forces. These are the dynamics that the agent of change will encounter, some of which will be his/her source of power as was outlined in Chapter 4.
Senior (1997:229) presents a hard systems model of change which provides a rigorous and systemic way of determining objectives or goals for change followed by the generation of a range of options for action and testing those options against a set of explicit criteria. Performance measures are identified as well as constraints on the achievement of the objectives. Aspects of this model can be useful to guide the process of operationalising the TRIC strategies. Ackoff’s conceptual framework for managing organisation-wide change suggests among other things, the development of an on-going communication plan (Swansburg & Swansburg, 1995:251). In the current study this communication plan can be incorporated into the existing departmental communication strategy. Havelock’s theory on change (Swansburg & Swansburg, 1995: 251) introduces elements which aim at building a relationship and gaining mutual acceptance between the agent and recipients. On the other hand Spradley’s model (Swansburg & Swansburg, 1995: 251) introduces the issue of constant monitoring of the change in order to develop a fruitful relationship between the change agent and the change system. The constant monitoring of change has relevance in the current study to prevent strategies not addressing what they aimed to address.

In his seven-phased theory, Lippitt (in Swansburg & Swansburg, 1995:251) provides an elaborate set of issues which have to be borne in mind by the change agent to ensure successful implementation of the change. He highlights that the change agent has to involve key people in top management and policy-making roles and win their commitment to the planned change; have the ability to deal with conflict and confrontation and must withdraw at a specific date after setting a written procedure or policy to perpetuate the change, but has to remain available for advice and re-inforcement. The change agent thus has the whole range of suggestions by these various authors to choose from in dealing with change. These strategies must be publicized to reach all stakeholders.
5.4 CHAPTER SUMMARY

Chapter five presented the TRIC strategies proposed for implementation in the Amathole District Municipality to facilitate effective collaboration between traditional and allopathic health practitioners to enhance and optimize service delivery. The TRIC strategies comprise three strategies which are intertwined and operate as an integrated system. The three strategies are the strategy to change the negative attitude of allopathic and traditional health practitioners, the communication strategy and the capacity building strategy. An implementation strategy incorporating a strategy to manage resistance to change was also developed to facilitate sustainability of the envisaged collaboration.

The next chapter will deal with the conclusions, limitations and recommendations emanating from the study.
CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This is the final chapter which brings the current study to a close. This chapter provides an opportunity for the researcher to illustrate to the reader whether the purpose of undertaking this study has been fulfilled and objectives as stated in chapter one attained. The researcher will therefore discuss the conclusions of the study and limitations and suggest areas for further research as emerged from the findings.

6.2 CONCLUSIONS

The interest of the researcher in undertaking this study was triggered in 2003 when the Traditional Health Practitioners Bill was gazetted. Chapter 2 (4) (1) of this Bill made provision for the establishment of the Interim Traditional Health Practitioners Council. One of the functions of this Council as outlined in Section 6 (2) (a) was to regulate and promote liaison between traditional health practitioners and other health professionals registered under any law. This left the researcher curious to know how these two groups of healers who are now required to liaise were relating to each other before this policy requirement and what the impact of the proposed Act would be on their respective practices. The researcher then realised that there was a need to develop and implement strategies to facilitate collaboration between the two groups of healers as their services were being used either concurrently or sequentially by the majority of the black communities in the Province of the Eastern Cape.

This research report reflects the journey undertaken by the researcher in the search for appropriate strategies to facilitate collaboration between allopathic and traditional health practitioners. The research topic was introduced in Chapter 1 and contextualised by doing a literature review. Local, national and global trends
that had resulted in a renewed interest in traditional healing and the obligation to introduce legislation to control the practice of traditional healers were discussed in this chapter. The researcher gave an overview of traditional and allopathic health systems enunciating the types of practitioners and their world views on health, illness and healing. The researcher described the various categories of traditional health practitioners from the perspective of other researchers and as defined by the Traditional Health Practitioners Act, Act 35 of 2004. The purpose of undertaking the study was spelt out; the objectives, research questions and the research design to be used were all introduced. The following research questions were posed to give direction to the study:

- What was the relationship between allopathic and traditional health practitioners in the Amathole District Municipality in the Province of the Eastern Cape prior to the legalisation of traditional healing and what has been the experience of these health practitioners as role-players in the healthcare delivery landscape in this municipality?
- What are the viewpoints of allopathic and traditional health practitioners regarding the impact that legalisation of traditional health practitioners will have on their respective practices and ultimately on healthcare delivery?
- What strategies can be developed to facilitate collaboration between allopathic and traditional health practitioners to optimise and complement healthcare delivery?

The conceptual framework guiding this study was derived from Leininger's theory of Cultural Care Diversity and Universality which was chosen because it emphasised culture and was therefore appropriate for this study as traditional healing is a culturally rooted healthcare practice. The terms that were used throughout the study were defined to facilitate the reader’s understanding. The researcher has used the words “liaison” and “collaboration” interchangeably throughout the study after consulting the dictionary definitions of the two words.
Chapter 2 detailed the research design used. To actualize Phase One of the research, a qualitative, exploratory, descriptive and contextual research design was used as the researcher wanted to capture the viewpoints of allopathic and traditional health practitioners as expressed by them in their own words. Data was collected from three groups of participants by conducting a focus group and individual interviews using a tape-recorder. The three groups comprised allopathic health practitioners forming Group 1; traditional health practitioners forming Group 2 and nurses who were also traditional health practitioners forming Group 3. When the researcher realised that contrary to the initial plan, participants in the focus group interview consisted only of nurses due to a challenge that emerged in the clinical situation, the focus group interview was complemented with individual interviews of four allopathic health practitioners including a doctor and pharmacist from different racial groups to meet the previously stated selection criteria. Findings from the four individual interviews forming a complementary group were similar to those of the focus group interview and were consequently integrated. Themes and sub-themes emerged from the results of the interviews of each group and these were discussed in Chapter 3.

Throughout the study the specific objectives that the researcher sought to attain were to:

- explore and describe the nature of the relationship between allopathic and traditional health practitioners before legalisation of traditional healing and their experience as role-players in the healthcare delivery landscape in the Amathole District Municipality;
- elicit the viewpoints of traditional and allopathic health practitioners regarding the impact on their practices of legalisation of traditional healing and
- develop strategies to facilitate collaboration between traditional and allopathic health practitioners to optimise and complement healthcare delivery
Each objective and the extent of its attainment will now be discussed.

6.2.1 Objective 1: To explore and describe the nature of the relationship between allopathic and traditional health practitioners before legalisation of traditional healing and their experience as role-players in the healthcare delivery landscape in the Amathole District Municipality

Findings revealed that there was no formal interaction between allopathic and traditional health practitioners in the Amathole District Municipality and their working relationship was characterised by a one-sided referral system with traditional healers referring patients to allopathic health practitioners and the latter group not doing likewise. Traditional surgeons were the only type of traditional healer that was enjoying reciprocal referral of patients with allopathic health practitioners as their working relationship had been formalised through the Application of Health Standards in the Traditional Circumcision Act, Act No 6 of 2001. The reason stated by traditional healers for continuing to refer patients to allopathic health practitioners despite the latter not doing likewise was that allopathic health practitioners had skills, technology and equipment to manage certain aspects of these patients. It was also noted that practitioners from both groups were referring patients among themselves according to their specialties and expertise.

The working relationship between the two groups of healers was also characterized by a negative attitude toward each other with inherent elements of misunderstanding each other and mistrust. Both types of practitioner were accusing each other of delaying referring the patients for either western medical care or traditional medicine and as a result, patients presented themselves when the disease was at an advanced stage. Traditional health practitioners expected patients that were sick due to diseases of cultural origin or man-made diseases
and those who talked about “thikoloshe and mafunyana” to be referred to them by the allopathic health practitioners. The researcher was therefore able to explore and describe from the perspective of the respective practitioners themselves, the nature of the relationship that existed between allopathic and traditional health practitioners as healthcare providers in the Amathole District Municipality.

6.2.2 Objective 2: To elicit the viewpoints of traditional and allopathic health practitioners regarding the impact on their practices of legalisation of traditional healing

Traditional health practitioners had ambivalent views regarding the impact that the new legislation on traditional healing would have on their practices. They cited economic benefits, elimination of unscrupulous healers and occupational protection as anticipated benefits resulting from implementation of the Act. They expressed concern about people who disguised themselves as traditional healers as they were exploiting the practice for gain and in so doing tarnished the image of traditional healers. Thus they hoped that the new legislation might assist in identifying and eliminating these bogus healers some of whom had acquired the skill to heal by sinister means (had undergone the “thwala” process). On the other hand nurses who were traditional healers hoped that following implementation of the Traditional Health Practitioners Act, they would enjoy such benefits as being used to conduct in-service education for traditional health practitioners; receiving royalties for discoveries regarding traditional medicines which could treat certain diseases; having their success stories publicized and being used more effectively in the clinical situation to determine whether a particular patient required the services of western-trained practitioners or traditional healers. The researcher anticipated that these beneficial elements would act as catalysts or driving forces in promoting the acceptability of the TRIC strategies.
While anticipating the above benefits, participants who were traditional health practitioners mentioned that they were threatened by a possibility of having to divulge information regarding their traditional medicines, an action that they feared might result in the wrath of their ancestors. They also felt threatened by the fact that as their practice would be monitored they would be arrested for errors in their practice. Some traditional healers were contemplating abandoning their practice because of being threatened by this Act. The fear of being arrested was associated with the arrest of a number of traditional surgeons by the Eastern Cape Department of Health for mismanaging the circumcision rite. The more experienced but not-so-well educated healers who were respected and patronised by their communities were the ones who threatened to quit the practice. Participants who constituted the focus-group interview were very superficial in discussing the impact of the Traditional Health Practitioners Act on their practice as they claimed that they were not well versed in the provisions of the Act as they had not participated in any process during its development. Focused communication interventions will have to be applied through implementation of the TRIC strategies to address these issues.

6.2.3 Objective 3: To develop strategies to facilitate collaboration between allopathic and traditional health practitioners to optimise and complement healthcare delivery

This objective was achieved as the researcher developed three strategies that were coined the TRIC strategies which aimed at facilitating collaboration between allopathic and traditional health practitioners. The conceptual framework on which these strategies were based was the Survey list by Dickoff et al. (1968: 423) as discussed in Chapter 4. The strategies have been proposed to address the needs of the two groups of healers as reflected in the themes and sub-themes that emerged from the findings of each group of the participants as was highlighted in Chapter 3. The strategies are therefore evidence informed through cross-validation with themes and sub-themes in Chapter 3. The proposed TRIC
strategies focus on changing the negative attitudes of both allopathic and traditional health practitioners toward each other; improving communication and building capacity. The communication strategy is the most pivotal as it permeates through the other two strategies. The researcher is of the opinion that addressing these three major areas will facilitate collaboration between allopathic and traditional health practitioners. The onus of implementing the strategies lies with the Eastern Cape Department of Health whose officials must serve as agents of change to ensure that the terminus is reached which is effective collaboration between allopathic and traditional health practitioners as reflected by a reciprocal referral system. Having developed these strategies, the researcher has achieved the purpose of her study and has made a valuable contribution to the planners of health services, programme managers, especially those responsible for primary healthcare and hospital services, other researchers and to the consumers of health services.

In this study trustworthiness was ensured by using Guba’s model on trustworthiness (Krefting, 1991:215). Guba’s model (in Krefting, 1991: 214-222) is based on the identification of four criteria of trustworthiness, namely, truth value, applicability, consistency and neutrality. The model defines different strategies of assessing these criteria in each type of research. These strategies assist the researchers in designing means for increasing the rigour of their qualitative studies and also for the readers to use as a means of assessing the value of the findings of qualitative research.

The ethical acceptability of the study was ensured throughout the research process and attention paid to the following issues: obtaining written permission to conduct the study from the Head of the Eastern Cape Department of Health, ensuring that participants understood and gave their signed informed consent and ensuring anonymity, confidentiality, privacy and freedom from exploitation and deception of participants.
A conceptual framework for the development of the strategies to facilitate collaboration between traditional and allopathic health practitioners based on the Survey List by Dickoff et al. (1968:415-434) was discussed in chapter 4.

The researcher is of the view that the qualitative research design that she has used in this study has assisted in articulating the appropriate strategies for implementation to facilitate collaboration between allopathic and traditional health practitioners that were discussed in chapter 5. What needs to be stated though is that while doing a literature review on the subject, the researcher noted with concern the tendency of writers to apply loosely and interchangeably the terms integration, co-operation, liaison, incorporation, and collaboration when referring to the desired working relationship between allopathic and traditional health practitioners. The inherent risk is that it can derail the thinking and focus of policy-makers and planners of healthcare services when developing policies pertaining to the working relationships between these two groups of health practitioners. Integration, for instance, is defined by the Webster dictionary (1998:376) as forming into one whole or blending into a functioning or unified whole. This definition presumes that entities come together to form something new that is functioning as an effective and orderly unit. The impression created when using this definition is that traditional and allopathic healing systems would merge into a new effective healthcare system; but the corresponding discussion of this point by the same authors implies a relationship of co-operation. In this study the researcher has used collaboration and liaison interchangeably.

6.3 LIMITATIONS OF THE STUDY

Although the study succeeded in attaining its stated objectives, it needs to be highlighted that there were limitations as will be outlined by the researcher below.

- This study was conceptualised in 2003 after the gazetting of the Traditional Health Practitioners Bill to regulate the practice of traditional
health practitioners. Traditional health practitioners in the Province of the Eastern Cape were then required to register for membership with the Provincial Traditional Healers Association in readiness for registration with the Interim Traditional Health Practitioners Council of South Africa. The requirement for the registration of traditional health practitioners had an impact on the current study. It caused the traditional health practitioners to be apprehensive about this study suspecting that it was a government ploy to invade their practice, steal their knowledge of traditional medicines or have them arrested for errors in their practice as had happened to the traditional surgeons who had been arrested for mismanaging the circumcision rite. Requesting them to sign the consent form compounded the suspicion and skepticism about the study. This resulted in some participants, especially the birth attendants being cautious and brief when responding to research questions and not spontaneous and elaborative and much probing had to be done to get more information. To illustrate this extra caution, two of the three participants who were traditional birth attendants even organised neighbours to be present during the interviews. The explanation given for the presence of the neighbours was that they wanted them to watch and listen to whether the participants were not implicating themselves in their responses. On observing this situation the researcher had to make a conscious effort to build trust and establish rapport, thereby creating a relaxed atmosphere. The researcher could not establish whether the participants, especially traditional birth attendants, were not at ease because of errors in their practice that they could have previously committed and were now panicking in case these were discovered or their uneasiness was purely based on the issue of arrested traditional surgeons.

- The researcher belonged to the same ethnic group, spoke the same language and lived in the same geographical area as most of Group 2 participants, that is, the traditional healers. Although this could have acted
as an advantage it became a limitation in some instances as was the case when the researcher tried in vain to probe about the existence of one cadre of an unscrupulous traditional health practitioner who, participants maintained to have undergone a “thwala” process instead of having “thwasad.” The researcher wanted to establish what the “thwala” process entailed. Admittedly, the researcher had heard this term before but its use was in relation to the acquisition of wealth through sinister means and not from the angle of healing. Most probably participants could have shed more light on this type of a healer if the researcher had been from a different racial group as they would have expected him/her not to know the concept of “thwala.”

- As has been indicated, the study commenced almost five years ago and along the way interrupted by policy changes relating to the Traditional Health Practitioners Act, Act 35 of 2004. When the constitutional validity of this Act was challenged by the Doctors for Life, that action made the researcher to be hesitant to continue with the study and this uncertainty affected the progress of the study. It must be reiterated that the study was initially based on Act 35 of 2004 but towards its completion this Act had changed to Act 22 of 2007 following the processes that had been undertaken after the challenge of its constitutionality by the Doctors for Life. However, the relevant section that was quoted by the researcher to have prompted her to undertake this study remained unchanged in both Act 35 of 2004 and Act 22 of 2007.

- The researcher could have interviewed more than one focus group of allopathic health practitioners but the reality of staff shortage in the clinical situation in all health facilities in the Amathole District Municipality was a prohibiting factor. This prompted the researcher to have an unintentional complementary group, Group 1(a) to address the identified deficit. This has been fully explained in the text.
Lastly, the study is being completed at the time that a new Service Transformation Plan is being introduced in the Eastern Cape Department of Health coupled with the revision of the Service Delivery Model. The Service Transformation Plan is an initiative of the National Department of Health aimed at achieving efficiency and safety norms for patients at different levels of care by ensuring appropriate, equitable and rational distribution of health facilities and human resources (Eastern Cape Department of Health, 2007:7). This is going to impact on the status of some institutions like certain district hospitals becoming community health centres and certain clinics being upgraded to become community health centres.

The revised Service Delivery Model that the province will be embarking on entails processes like de-complexing of hospital complexes and de-clustering of district hospitals to their original status as separate entities as they were before introducing the concept of complexes and clusters. These structural changes may impact on the nomenclature that has been used in this study and on portfolios of agents proposed as responsible for the implementation of the TRIC strategies. To illustrate this point, in chapter 1 reference was made to five Local Service Areas comprising the Amathole District Municipality and lately these geographic demarcations are referred to as Health Sub-districts.

6.4 RECOMMENDATIONS

In the light of the findings and concerns identified in this study, the researcher would like to make the following recommendations with specific reference to policy-making, medical, pharmacy and nursing education, nursing and medical practice as well as research.
6.4.1 IMPLICATIONS FOR POLICY MAKING

Policy-makers, planners of health services and healthcare providers need to have a common understanding, interpretation and definition of the terms “integration”, “incorporation” “co-operation”, “liaison” and “collaboration” as currently there is loose application of these terms and a tendency to use them interchangeably. This can be confusing and may not be conveying the intended message regarding the desired working relationship between traditional and allopathic health practitioners.

Based on the findings in this study, the traditional health system should run as a parallel or inclusive system to the allopathic health system with identified areas of collaboration, namely sharing resources like budget, equipment, facilities and information as the two healing systems are premised on different ideological stances. Sharing facilities does not imply that traditional health practitioners should be allowed to treat their patients whilst they are hospitalized as their treatment modalities may differ from western methods and their traditional medicines can interact with medicines prescribed by the doctors. While ventilation in the ward is required to provide patients with fresh air, some traditional health practitioners may want to have the windows closed to fumigate by burning their concoctions of traditional medicines to expel impurities to heal their patients. It is therefore not feasible to have patients treated by their traditional healers while admitted in hospital more so that there are patients from different cultures who do not even believe in traditional healing. Sharing facilities therefore is making special reference to the proposed Collaboration clinics that traditional health practitioners will be free to refer their patients to.

A referral policy already exists in the Amathole District Municipality albeit in draft form. To promote collaboration, the referral chain outlined in this policy has to accommodate traditional health practitioners as they are the first contact made by black communities in search for health services even before presenting themselves to the clinics. The proposal made in this text to designate certain
clinics as Collaboration clinics is in a way positioning traditional health practitioners in the referral chain. This arrangement which allows reciprocal referral of patients between traditional and western-trained practitioners should be endorsed by the relevant standards-generating councils controlling their practice, namely, the Nursing Council, Interim Traditional Healers Council and the Health Professions Council.

There should be a representative of traditional health practitioners in all governance structures in the Province especially for primary healthcare services. These structures include the Provincial Health Consultative Forum where the Member of the Executive Council for Health discusses health issues with stakeholders; the District Health Advisory Committee and Hospital Boards and Clinic Committees. This exposure will entrench the implementation of the three “Cs” comprising the TRIC strategies that were described in Chapter 5. Traditional health practitioners will have the opportunity of communicating/interacting with colleagues who are western-trained practitioners, gaining knowledge and insight from them, that is, being empowered and in the process their attitude will gradually change especially when they realise that their concerns and contributions are also being addressed. Participation of traditional healers in these structures may also help to change the negative attitude that allopathic health practitioners stated to be having against traditional health practitioners. It has to be borne in mind that although traditional healing is mostly practised by poorly educated and illiterate healers, there are medical practitioners, nurses, teachers and other professionals from other fields with graduate and post-graduate qualifications who are traditional healers and can comfortably be part of these structures.

Policy-makers in the Department of Health must consider the inclusion or absorption of traditional surgeons and traditional birth attendants into the provincial health system as Community health workers. Their skills and knowledge should be sharpened through short courses and evaluated and
accredited by the relevant councils. In some cases the initial step will be to subject them to Adult Basic Education and Training. The position of these two categories is not questioned by the allopathic health practitioners except expressing concern about aspects of their practices which are harmful to themselves and their clients, like the use of the same instrument for more than one boy when performing circumcision and delivering of a woman in labour barehanded, that is, without wearing gloves. Capacity building through the proposed training will rectify such practices. Traditional birth attendants cannot be wished away as they are a valuable health resource especially in deep rural areas some of which are accessible only by a helicopter. Paying the traditional surgeons a flat fee from the provincial budget will also assist in curbing the tendency of certain surgeons charging exorbitant fees for performing this rite resulting in families resorting to cheap, inefficient or bogus traditional surgeons. Use of cheap inefficient traditional surgeons has resulted in the number of initiates admitted into hospitals because of sepsis, dehydration, haemorrhage, penile amputations and botched circumcision not decreasing despite preventive medical interventions by allopathic health practitioners through the implementation of the Application of Health Standards in Traditional Circumcision Act, Act No 6 of 2001.

**6.4.2 IMPLICATIONS FOR MEDICAL, PHARMACY AND NURSING EDUCATION**

Culture and alternative healing systems must be included in the curriculum of nursing, medical and pharmacy students so that they become acquainted with this type of healing at an early stage of their careers. As part of their community-based education programme these students must visit traditional healers in their workplaces so that they can see the dispensary (*Umrawule*) and training school (*iphehlo*) and give prompt advice on the necessary interventions.
The Department must consider using the nurses and medical doctors who are also traditional health practitioners to provide in-service training for traditional health practitioners as they understand both worlds, especially the intricacies of traditional healing.

Traditional health practitioners must be represented in the Provincial Training Committee and in the District Training Committees so that their training needs become well articulated. Scheduled activities like workshops, campaigns, seminars and short courses must be hosted to strengthen collaboration between allopathic and traditional health practitioners.

There should be record of all training programmes for traditional health practitioners offered by the universities, health institutions, provincial programme managers and other community-based organisations. These programmes must be appraised for relevance and quality and a uniform training programme be developed for each category of healer and accredited by the relevant council. Inspection of existing training institutions for diviners (amaphehlo) must be conducted by the Interim Council of Traditional Health Practitioners and if they meet the training requirements be accredited for training. In addition to issuing oxtails, graduates of these schools must be certificated on completion of training to provide them with the occupational protection that they had mentioned during the interviews as discussed in chapter 3.

6.4.3 IMPLICATIONS FOR NURSING AND MEDICAL PRACTICE

Traditional health practitioners should participate in all strategic planning workshops and strategic conversation sessions which are hosted by the Department of Health on scheduled times. Such workshops and meetings will provide an opportunity for the two groups to address areas of concern including any practices of each group which undermine the practices of the other group. They will also agree on diseases which can be managed by traditional healers.
and those that have to be referred. Traditional healers must be educated on the signs and symptoms of common diseases in this district which include tuberculosis, diabetes mellitus, hypertension, HIV and AIDS, Sexually transmitted diseases and children’s diseases. Traditional healers must also inform allopathic health practitioners about the types of patients that have to be referred to traditional healers like the ones that were highlighted during interviews, namely, those experiencing barrenness which does not respond to western medicines; those suffering from enuresis being over ten years of age; and patients with psychosomatic illnesses especially those talking about “amafufunyana” and “thikoloshe”. Mutual referral of patients can be confined to these types of patients identified by both groups and this arrangement be piloted in the designated Collaboration clinics in one Health Sub-district. Where there are successes with the use of a particular traditional medicine, this medicine should be sent to the laboratory for testing for efficacy and safety and if the results are good this can be published in professional journals and the traditional health practitioner who shared this knowledge must be acknowledged. In order to build capacity and dispel fears and mistrust, traditional health practitioners must be present when doing clinical trials on their medicines.

Open days can be arranged in each Health Sub-district to expose each group to the practices of the other. Traditional health practitioners should take rounds in the various hospital departments like X-Ray and in laboratories and wards to see the equipment and technology used for investigations, treatment and rehabilitation. A decision has to be made on whether doctors, pharmacists, nurses or other allied health professionals who are also traditional healers should be regarded as having additional qualifications and remunerated as such. There is a need to establish whether they add value in health service delivery.
6.4.4 IMPLICATIONS FOR FURTHER RESEARCH

Further research is needed in the following areas:

- The attitude of communities on integration of the traditional healing system into the national health system. The views of different racial groups must be elicited to ensure a holistic trans-cultural perspective.
- To determine the value of allopathic health practitioners who are also traditional health practitioners in enhancing service delivery.
- Research on the Pilot phase of implementation of the TRIC strategies in the Eastern Cape and evaluation of the effectiveness of the strategies.

6.5 CONCLUDING REMARKS

This study was conducted at an appropriate time as the period between 2001-2010 had been declared by the Organisation for African Union as the Decade for African Traditional Medicine.

The study has highlighted that allopathic and traditional health practitioners have the same goal: that of healing a patient; but, although they were providing healthcare services to the same communities in the Amathole District Municipality, there was no interaction between them; instead they mistrusted each other and displayed a negative attitude towards one another. Traditional surgeons were the exception as their relationship with allopathic health practitioners had been formalised through the Application of Health Standards in Traditional Circumcision Act, Act No. 6 of 2001.

Facilitating collaboration between traditional and allopathic health practitioners is imperative considering the realities of staff shortages and disease burden challenging the Province of the Eastern Cape. The existence of Multiple and X-treme drug resistant Tuberculosis, HIV and AIDS and life-style diseases requires a concerted effort to address them.
The researcher succeeded in developing and describing the strategies which would facilitate this collaboration focusing on fostering communication between the two groups, building their capacity and changing their negative attitude. This brought to an end the purpose of having undertaken the study.


CONSTITUTIONAL COURT OF SOUTH AFRICA. 2006. Doctors for Life International versus the Speaker of the National Assembly and others. CCT 12/05. Media summary.


MOTOTO, OM. 1999. *The willingness of traditional healers regarding collaboration with western psychiatric health care*. Bloemfontein: University of...


MSELEKU, T. 2006 Opening remarks made at the conference on institutionalisation and operationalisation of traditional medicine held at Kopanong Conference centre at Benoni.


MZANA, N. 2003. An informal conversation held with the researcher on practices of traditional birth attendants in the eastern part of the Province of the Eastern Cape on 13 September 2003.


TALBOT, LT. 1994  *Principles and practice of nursing research.* St Louis: Mosby.


TSHABALALA-MSIMANG, M. 2006.  Closing remarks by the Minister of Health (South Africa) at the National Traditional Medicine workshop at Kopanong, Benoni. An unpublished paper.


ANNEXURE A

CORRESPONDENCE PERTAINING TO THE GRANTING OF PERMISSION TO CONDUCT RESEARCH
The Member of the Executive Council for Health
Department of Health
Private Bag x 0038
Bisho.
5605

Attention: The Superintendent General

Dear Sir

REQUEST TO CONDUCT RESEARCH

I am a student in the University of Port Elizabeth pursuing a Doctoral degree in Nursing Science. In fulfillment of the requirements of this programme, I am expected to undertake research in any health problem. My area of interest is on indigenous knowledge systems with special focus on traditional healing. The title of my study is “Strategies to facilitate collaboration between allopathic and traditional health practitioners.”

The objectives of the study are to describe the nature of the relationship between traditional and allopathic health practitioners prior to the legalisation of traditional healing, their experience as role-players in the healthcare delivery landscape in the Amathole District Municipality as well as their perception of the impact that the legislation on traditional healing will have on the respective practices of allopathic and traditional health practitioners. Within that identified context, strategies to facilitate collaboration between traditional and allopathic health practitioners will be developed and proposed to optimize and complement health service delivery.
I herein request permission to conduct a focus group interview among nurses, doctors and pharmacists working in public health institutions in the Amathole District Municipality and to further make use of facilities like the boardroom, office or classroom in these health institutions. The focus group interview will comprise 5-10 participants. Individual interviews will also be conducted with nurses who are also traditional health practitioners. Only those health practitioners who are willing to participate in the study will be included. The interviews will be tape recorded to ensure accuracy of the data. Participants will be made aware that they are free to withdraw from the study at any time. A research report will be made available to the Eastern Cape Department of Health on completion of the study.

I hope that my request will be considered favourably. Attached is the research proposal.

Yours faithfully

____________________________________
MAUDLINE NOMAZWI TEMBANI (Miss)
ANNEXURE B

LETTER AND FORM TO THE ALLOPATHIC HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY
Dear Colleague

REQUEST TO PARTICIPATE IN THE RESEARCH STUDY

I am a student in the University of Port Elizabeth pursuing a Doctoral degree in Nursing Science. In fulfillment of the requirements of this programme, I am expected to undertake research on a health issue. I intend developing strategies to facilitate collaboration between allopathic and traditional health practitioners.

The objectives of my study are to describe the nature of the relationship between traditional and allopathic health practitioners prior to the legalisation of traditional healing, their experience as role-players in the healthcare delivery landscape in the Amathole district Municipality as well as their perception of the impact that the legislation on traditional healing will have on the respective practice of allopathic and traditional health practitioners. Within that identified context, mechanisms will be established to assist in developing strategies to facilitate collaboration between traditional and allopathic health professionals to optimise and complement health service delivery.

I herein request you to participate in this research study by being part of a focus group interview comprising of not more than 12 health practitioners. I have attached information that will help you to understand the study, and what you will be asked to do during the study, the risks and benefits, and your rights as a participant. If anything in the form is not clear to you, please ask me to explain.
I am further requesting you to give your written informed consent to participate by signing and dating a consent form and putting your initials against each section to indicate that you understand and agree to the conditions.

You have the right to ask questions concerning the study at any time. You should also immediately report to me any new problems during the study. The telephone numbers of the researcher are provided. Call these numbers if you have any questions or worries about the study.

Participation in the research is completely voluntary. You are not obliged to take part in the research. If you choose not to participate, your present and/or future medical care will not be affected in any way and you will incur no penalty and/or loss of benefits to which you may otherwise be entitled.

If you agree to take part, you have the right to change your mind at any time during the study. You are free to withdraw this consent and discontinue participation without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination so that the research may be stopped in an orderly manner.

The researcher may choose to dismiss you from the study without regard to your consent if you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes it is not in your best interest to continue in this study, or for administrative reasons.

Your identity will remain confidential. The results of this research study may be presented at scientific conferences or in specialist publications, but your identity will not be shown.

Yours sincerely,

Nomazwi Maudline Tembani (Miss)
LIST OF ALLOPATHIC HEALTH PRACTITIONERS WILLING TO PARTICIPATE

NAME OF THE INSTITUTION:

<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY OF THE ALLOPATHIC HEALTH PRACTITIONER</th>
<th>YEARS OF EXPERIENCE AFTER QUALIFYING</th>
<th>CLINICAL AREA</th>
<th>WILLING: YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEXURE C

LETTER AND FORM TO THE TRADITIONAL HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY
Camagu Mhlekazi

**ISICELO SOKUTHABATHA INXAXHEBA KUPHANDONZULU**

NdingumfundikwiDyunivesiti yaseBhayi ndifundela imfundo enomsila yokuba nguggirha kwezokonga. Ukuze imfundo yam igqibelele, kulindeleke ukuba ndenze uphandonzulu kuwo nawuphina umba odla umzi kwezempilo.

Umba endifuna ukuwuqwalasela ngoweenyangi zemveli. Ndinga ndingazi okokuba iinyangi zemveli nabaqeqeshelwe ukuxelenga kwezempilo ngokwasemzini, behlelisene, besebenzisana njani ngaphambili, waye wona lo mthetho mtsha unqamene neenyangi zemveli uzakuyibeka phi na intsebenziswa phakathi kwala maqela mabini kule ngingqi kaMasipala waseMathole.

Ndinesicelo ke sokuba ube ngomnye weenyangi zemveli oza kuthabatha inxaxheba kolu phandonzulu, nozikukhe aphefumle kulo mba wokufumana iindlela ezingasebenzisana ngayo ezi ndidi zombini zeenyangi ukuze zenze uvimba oluqilima kwinkonzo yonyango kule ngingqi kaMasipala waseMathole.

Ndifuna ukukuqinisikisa ukuba yonke incoko yethu negama lakho azizokupapashwa. Igalelo olenzileyo lona liza kubakho kwiziphumo zolu phando ndilwenzayo neziya kuthi zibe yincwadi egcinwa kumathala eencwadi efundwa nguwonke-wonke onomdla wokwenza oko, kwihlabathiliphela.
Ndinga ungandicamagushela nakumanyange ngesi sicelo, ubazise okokuba le ntombi yamaZotsho umaGadluma, umaCekwana, umaSibande umaTshutsha, lo mzukulwana wamaZizi, ooDlamini, ooJama, ooSijadu uzama ukufumana indlela eyiyo yentsebenziswa wakathi kweenyangi zemveli neenyangi ngokwasemzini, nto leyo eya kuthi incede uluntu luphela.


Ozithobileyo,

______________________
Nomazwi Maudline Tembani (Miss)
Dear Sir

REQUEST TO PARTICIPATE IN THE RESEARCH STUDY

I am a student in the University of Port Elizabeth pursuing a doctoral degree in Nursing Science. In fulfilment of the requirements of my studies I am expected to undertake research in any health problem. The issue that I would like to explore is that of traditional healers. I would like to find out how traditional and allopathic health practitioners have co-existed in the past, what their working relationships were as well as how the new legislation on traditional health practitioners will impact on the working relationships of these health practitioners in the Amathole District Municipality.

I therefore request that you be one of the traditional healers who will participate in this study and air your perceptions on the mechanisms that can be employed to develop a strategy to facilitate collaboration between traditional and allopathic health practitioners to complement and optimize health care delivery in the Amathole District Municipality.

I would like to reassure you that your name and our conversation on this issue will be treated confidentially. Your contributions however, will form part of the final research report which will be compiled into a book available in libraries to be read by whoever so wishes throughout the world.

I would like to request you to further appeal to your ancestors on my behalf for permission to conduct this study using a tape recorder to record our conversation. May you explain to them that I, the daughter of the AmaZotsho
clan - the Msalis, Gadlumas, Cekwanes, Sibandes, Tshutshas, the grandchild of the amaZizi, the Dlaminis, Jamas Sijadus, is attempting to develop strategies to facilitate collaboration between traditional and allopathic health practitioners so that the entire nation can benefit.

May I explain that you are not compelled to participate in the study, but if you agree to be one of those who will air their views on this issue, please sign your name in the attached form and consent form.

Yours faithfully,

Nomazwi Maudline Tembani
<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY OF THE TRADITIONAL HEALER</th>
<th>EXPERIENCE IN YEARS</th>
<th>WILLING: YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INFORMED CONSENT FORM

TITLE OF THE RESEARCH PROJECT: STRATEGIES TO FACILITATE COLLaborATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS

PRINCIPAL INVESTIGATOR: Nomazwi Maudline Tembani

ADDRESS: Department of Nursing
Faculty of Health Sciences
Nelson Mandela Metropolitan University
Province of the Eastern Cape.

CONTACT TELEPHONE NO: 0833533184

<table>
<thead>
<tr>
<th>DECLARATION BY THE PARTICIPANT</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, ...........................the undersigned, residing at in my capacity as the participant,</td>
<td></td>
</tr>
<tr>
<td>A. HEREBY CONFIRM AS FOLLOWS:</td>
<td></td>
</tr>
<tr>
<td>1. I was invited to participate in the abovementioned research project which is being undertaken by Nomazwi Maudline Tembani of the Department of Nursing in the Faculty of Health Sciences at the University of Port Elizabeth</td>
<td></td>
</tr>
</tbody>
</table>

| 2. The following aspects have been explained to me: | Initial |
| 2.1 Aim: The researcher wants to establish the nature of the relationship between traditional and allopathic health practitioners prior to the legalisation of traditional healing, their experience as roleplayers in the health care delivery landscape in Buffalo City, Province of the Eastern Cape and their perception of the impact that the legislation on traditional healing will have on their respective practices. The information will be used to develop a framework for collaboration between traditional and allopathic health practitioners to optimize and complement care delivery. |        |
2.2. Procedures: I understand that I will have to participate in a focus group interview comprising of not more than 12 participants

2.3 Risks: As far as has been explained to me there are no foreseeable risks that I will incur by participating in this study

Possible benefits: Through sharing my experiences and viewpoints I will assist in developing a framework for collaboration between allopathic and traditional health practitioners and this will optimize service delivery to the benefit of all community members

Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators

Access to findings: Any new information or benefit that develops during the course of the study will be shared with me

Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect my present or future medical care/employment/lifestyle.

3. The information above was explained to me by Nomazwi Tembani in English. I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization

5. Participation in this study will not result in any additional cost to myself

B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVEMENTIONED PROJECT.

Signed/confirmed at ..........(place) on.............(date)

Signature of participant                Signature of witness
LETTER TO THE NURSES WHO ARE TRADITIONAL HEALTH PRACTITIONERS REQUESTING PARTICIPATION IN THE STUDY
Dear Colleague

REQUEST TO PARTICIPATE IN THE RESEARCH STUDY

I am a student in the University of Port Elizabeth pursuing a Doctoral degree in Nursing Science. In fulfillment of the requirements of this programme, I am expected to undertake research on a health issue. I intend developing strategies to facilitate collaboration between allopathic and traditional health practitioners.

The objectives of my study are to describe the nature of the relationship between traditional and allopathic health practitioners prior to the legalisation of traditional healing, their experience as role-players in the healthcare delivery landscape in Amathole District Municipality as well as their perception of the impact that the legislation on traditional healing will have on the respective practice of allopathic and traditional health practitioners. Within that identified context strategies will be developed to facilitate collaboration between traditional and allopathic health professionals to optimise and complement health service delivery.

I herein request you to participate in this research in your capacity as a nurse and traditional healer. I have attached a form for you to complete. If anything in the form is not clear to you, please ask me to explain.

I am further requesting you to give your written informed consent to participate by signing and dating a consent form and putting your initials against each section to indicate that you understand and agree to the conditions.
You have the right to ask questions concerning the study at any time. You should also immediately report to me any new problems during the study. The telephone numbers of the researcher are provided. Call these numbers if you have any questions or worries about the study.

Participation in the research is completely voluntary. You are not obliged to take part in the research. If you choose not to participate, your present and/or future medical care will not be affected in any way and you will incur no penalty and/or loss of benefits to which you may otherwise be entitled.

If you agree to take part, you have the right to change your mind at any time during the study. You are free to withdraw this consent and discontinue participation without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination so that the research may be stopped in an orderly manner.

The researcher may choose to dismiss you from the study without regard to your consent if you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes it is not in your best interest to continue in this study, or for administrative reasons.

Your identity will remain confidential. The results of this research study may be presented at scientific conferences or in specialist publications, but your identity will not be shown.

Yours sincerely,

Nomazwi Maudline Tembani (Miss)
LIST OF ALLOPATHIC HEALTH PRACTITIONERS WHO ARE ALSO TRADITIONAL HEALERS WILLING TO PARTICIPATE

<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY OF THE ALLOPATHIC HEALTH PRACTITIONER</th>
<th>YEARS OF EXPERIENCE AFTER QUALIFYING AS A NURSE</th>
<th>CATEGORY OF THE TRADITIONAL HEALER</th>
<th>YEARS OF EXPERIENCE AFTER QUALIFYING AS A TRADITIONAL HEALER</th>
<th>WILLING: YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEXURE F

PROTOCOL FOR THE INDEPENDENT CODER
PROTOCOL FOR THE INDEPENDENT CODER

Dear colleague

I am forwarding to you transcribed interviews which you have to analyse as was requested, using the following steps:

- Read through all the transcriptions carefully while bracketing and intuiting to get a sense of the whole.
- In analyzing the data, use the following eight steps proposed by Tech (in Creswell, 2003:192):
  - Get a sense of the whole. Read through all of the transcriptions carefully jotting down some ideas as they come to mind.
  - Pick one interview and go through it asking yourself “what is this about? Do not think about the substance of the information but rather its underlying meaning. Write thoughts in the margin.
  - When you have completed this task for a number of informants, make a list of all topics. Cluster together similar topics. Form these topics into columns that can be arranged into major topics, unique topics and left overs.
  - Now take this list and go back to your data. Abbreviate your topics as codes and write codes next to the appropriate segments of the text. Try out this preliminary organizing scheme to see whether new categories and codes emerge.
  - Find the most descriptive wording for your topic and turn them into categories. Look for reducing your total list of categories by grouping topics that relate to each other. Perhaps draw lines between your categories to show their inter-relationship.
  - Make a final decision on the abbreviation for each category and alphabetize these codes.
- Assemble the data material belonging to each category in one place and perform a preliminary analysis.
- If necessary, recode your existing data

Thank you for your co-operation

_____________________
N.M TEMBANI
Doctoral nursing student
ANNEXURE G

TRANSCRIPTION OF AUDIO-TAPED FOCUS GROUP AND INDIVIDUAL INTERVIEWS
FOCUS GROUP INTERVIEW

GROUP 1 PARTICIPANTS: ALLOPATHIC HEALTH PRACTITIONERS

DATE: 9.08.2006
TIME: 11H00- 12H45

CONTEXT:

PHYSICAL SETTING:
- The focus group interview was conducted in a public hospital in a small nurses’ office in the Amahlathi Local Municipality which is part of the Amathole District Municipality.

PARTICIPANTS:
- A homogenous group comprising of six black female registered nurses working in the same hospital.
- The participants were selected using purposive sampling from a variety of wards, namely, maternity, paediatric, medical, surgical and the TB wards as well as the Out Patients Department and psychiatric clinic.
- The years of experience of participants as registered nurses ranged from 5 to 41 years
- Their professional preparation varied from a Diploma in General Nursing and Midwifery to acquisition of an additional qualification in Psychiatric nursing, Paediatric Nursing Science to a Bachelor of Arts in Nursing Science
- In this institution, a rotation system is used to allocate nurses in different clinical areas, consequently each participant has had experience of working in almost every area including rural clinics
**KEY:**

**R**: RESEARCHER  
**P**: PARTICIPANT

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>I would like you to share experiences that you have as western trained health professionals who were rendering services to the same communities where Traditional health practitioners also operated before legalisation of traditional healers. How were your working relationships with Traditional health practitioners?</td>
<td></td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>My experience as a sister working in OPD is not with the traditional healer as such but that there will be patients presenting with diarrhea, some with a distended abdomen, but they won’t say they have been attended by a Traditional healer. When you ask them whether they were attended by a traditional healer they usually say no they had not, but you would see that the child is dehydrated and has a smell of traditional medicine but you would find that when you try to put up the drip it’s difficult to get the veins, and what is annoying is that the traditional healers don’t refer and state what they have done. So we end up not knowing what was given or done to the patient.</td>
<td></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>You say you were annoyed that traditional healers did not refer. Did you expect the traditional healers to refer to you and state what they have done?</td>
<td></td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>Yes I expect them especially now that they have an act legalizing them.</td>
<td></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Before the legalization of traditional healers, did you expect them to refer patients to you?</td>
<td></td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>I would not expect them to do that, because you know I’m talking from experience, we usually tell them not to go to traditional healers because of Number 1, Number 2, forgetting that the traditional healers are the background of our culture</td>
<td></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>You are mentioning Number 1, Number 2. Can you explain what you mean by that?</td>
<td></td>
</tr>
</tbody>
</table>
To answer that for my colleague, the reason why we discourage them from seeing traditional healers is because the medicines of traditional healers are not sterile, and they do not wash their hands, whereas we as health professionals are promoting cleanliness and use of containers and medicines that are sterile.

Yes, traditional healers are not using sterile things and number 2 they are not using measurement.

You have mentioned the issue of measurement. Can you explain that?

Yes they are not using measurement in that they just mix the herbs. Here we have measurements.

Mixing the herbs, I don’t seem to understand you.

Yes, they are mixing the medicines, but my problem is the measurement. Here in hospital we are giving the medicines according to the weight of the patient. We are not just giving, so traditional healers…they are just giving the medicines. If it is a child, they don’t give it as a child. They give it as if it’s an adult. So they are doing sometimes….. overdosing the client.

So the danger there is overdosing?

Yes, the danger is over-dosage. So here in hospital we haven’t got that danger because we know how to give that client the medicine correctly according to the measurement and the weight of the patient.

OK. We are still sharing our experiences as health practitioners in the health care delivery landscape where other health workers including traditional healers practiced their profession.

Mhm, as I am working here, I work in the Paediatric Ward. We have a problem there in Paeds. Sometimes children are coming with severe diarrhoea. They have been seeing a traditional healer. So the traditional healer is giving more danger to the patient as the patient is having diarrhoea. Here in hospital when the patient comes with diarrhoea we rehydrate the child, but with traditional healers, they give more medicine like they give an enema.
<table>
<thead>
<tr>
<th>R</th>
<th>How did you get to know that these children had been to the traditional healers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>Getting the history from the mother to find out how long has the child been ill and she would state that the child had been ill for 2 to 3 weeks and that if you ask why she is only bringing the child now she would say no, as AmaXhosa we… “besisatshona ngapha, nangapha.” On seeing that the condition does not heal they come to hospital. “Besisatshona ngapha nangapha” Literally meaning “we had gone this side and that side” but meaning they had gone to seek help in other places</td>
</tr>
<tr>
<td>R</td>
<td>So when they said they had been to this place and that place, you assumed that they had been to traditional healers</td>
</tr>
<tr>
<td>P4</td>
<td>No, we asked them what help did they get from where they had been and they would say it</td>
</tr>
<tr>
<td>R</td>
<td>Did this affect your practice in any way?</td>
</tr>
<tr>
<td>P4</td>
<td>Yes, because sometimes a person goes to the traditional healer not that sick, but because they are given strong medicine that is not measured, it causes them to be worse, so we are experiencing that complication in hospital</td>
</tr>
<tr>
<td>R</td>
<td>From what you are saying, I am sensing that patients tend to start with traditional healers before they go to allopathic health practitioners. Is that the case?</td>
</tr>
<tr>
<td>P4</td>
<td>Yes, I can say they start with traditional healers, because in our culture as we are Xhosas we believe in traditional medicine and they usually say when we ask them why they like traditional healers, they say they grew up using bitter medicines “ookrakrayo”at their homes So they don’t like the sweet medicines which are given in hospital.. as if… &quot;ookrakrayo&quot;(Aloe preparations- my own interpretation).</td>
</tr>
<tr>
<td>R</td>
<td>As if?</td>
</tr>
<tr>
<td>P4</td>
<td>These sweet medicines seem as if they don’t heal them properly. They trust those bitter medicines. Even when I used to work for a long time in rural facilities working with clients from rural areas, most of those clients were used to traditional healers that is where they used to go whenever they got a problem</td>
</tr>
<tr>
<td>R</td>
<td>You know really I’ve been thinking that clients start in the clinics</td>
</tr>
</tbody>
</table>
P4 No, they start with traditional healers. Even in cases of pulmonary tuberculosis, that is TB, it’s where they used to go and they used to be told there that they had been kicked by an “impundulu” when they coughed up blood and I think the Department thought then that it should make a good working relationship with traditional healers and invited them to work with nurses and doctors.

| Impundulu is a lightning bird |

R Was this working relationship aimed at dealing with TB or with other diseases as well?

P4 No, because we also used to get babies with diarrhea and those babies with diarrhea you find that they used to be dehydrated, so we nurses used to invite and educate the traditional healers about the signs and symptoms of diarrhea, the sunken eyes, sunken fontanelle so that they know and not think that the baby has been bewitched if the baby is dehydrated. Traditional healers were even taught in their language to prepare home made rehydration solution. But all those things stopped.

R What stopped these if I may ask?

P4 With the change of hands in administration of health services, that was abandoned. But even then not everybody was doing this. It was not properly organised. I think that's why it did not last.

R So this was not well organised?

P4 No, this was not an organised thing, but it was in those isolated instances where you as a community nurse you felt you had to have traditional healers in your health team to address a problem you were facing, like diarrhea in children.

R Mhm

P4 For instance I would like to share with you, with the disease that we now have that is HIV & AIDS. I will give a short story about a client that I met in one of the rural clinics in Amathole District Municipality. The client was diagnosed with a full blown HIV. This woman was so ill at home but the whole family did not know. The mother told me that she was worried she could not sleep because of this daughter of hers who...
was so ill. She told me “sister I’m supposed to take my daughter to a traditional healer because I’ve been told that I must also slaughter a beast so that she can get better.” This mother also did not know the status of her daughter. So I counselled the young woman and told her that it is important for the mother to know her status because I was thinking of the expenses that the mother would go through on slaughtering a cow meanwhile the daughter knew that she was HIV positive. She knew that she was suffering from that disease, so at the end of that counseling, she agreed to tell her mother of her status. So at least I prevented a situation where a cow was going to be slaughtered for nothing.

<table>
<thead>
<tr>
<th>R</th>
<th>Who had suggested the slaughtering of this cow?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>It was the traditional healer. The family had taken this girl to a traditional healer. The traditional healer told them to slaughter a beast so that she could be cured</td>
</tr>
<tr>
<td>R</td>
<td>Does that imply that traditional healers at times recommend inappropriate treatment?</td>
</tr>
<tr>
<td>P4</td>
<td>Yes, sometimes they do. I am glad that the Department is recognizing traditional healers with this Act because it means they will be invited like we used to do but that died as I said when we were still the Ciskei</td>
</tr>
<tr>
<td>R</td>
<td>Surely you wanted to tell me something with that story about the HIV positive girl</td>
</tr>
<tr>
<td>P</td>
<td>What I wanted to say was that if we could invite those traditional healers who asked clients to kill the cows to be healed from HIV and tell them look, these are signs of HIV, please refer these patients to hospital or clinic then we would be successful in the way we did in Ciskei for children with diarrhea and TB patients coughing up blood</td>
</tr>
<tr>
<td>R</td>
<td>OK, let’s continue, I am still interested in your experiences as role players in health service delivery in the Amathole district Municipality</td>
</tr>
</tbody>
</table>
As I have been working in maternity, we have a problem of admitting newborn babies about two weeks after birth, whereby they have been taken by their mothers to traditional healers because the baby was crying the whole night. Seemingly they think that the baby has “umoya” So they have taken that baby to the traditional healer where he is given a medicine that will take out the “umoya” according to their culture, only to find that, that medicine will cause abdominal distention in the baby.

R | So in maternity ward you experience problems with the newborns?
---|---
P6 | Not only, as some mothers especially the primigravidas we hear from them that they have been taken by their mothers to a traditional healer and given a medicine called “umchamo” wemfene” (a baboon’s urine- my interpretation) so that they don’t delay when they deliver. They say that.

R | Does that impact on your practice in any way?
---|---
P6 | Yes, it does because some come up with problems that they don’t feel the foetal movements. Some complain that the baby is no more kicking as normal

R | I am listening
---|---
P3 | Previously I said the traditional healers are giving… are overdosing the clients. When you are giving the medicine in hospital you know that each medicine is given for example about 7 days and not more, but the traditional healers have no definite time. They are just giving the medicine and the person is just taking the treatment for an indefinite time and that is dangerous to the client because it is sometimes damaging the internal parts of the client

R | Mmh
---|---
P | And again we have this disease that was mentioned by my colleague which is world wide which is HIV and AIDS. Most of our people are affected by it. We experience problems in this area too as the person being HIV positive as he sees that he is weak and is supposed to go to the hospital for help, instead he goes to the traditional healer where he may be given a medicine that will cause diarrhea. Maybe this
person had diarrhea before but not so severe, but now develops severe diarrhea and get to us in that state and becomes a problem. We eventually help as we have the things with which to help. That is why I am saying even to the victims of HIV they must not rush to traditional healers. I am not saying they are not helped by the traditional healers, but when they come to us, by the time they come to us they are a problem. You last see a person looking better, then after seeing the traditional healer she is worse.

<table>
<thead>
<tr>
<th>Ja</th>
</tr>
</thead>
</table>

P2 To add more to what my colleagues have said, there were traditional healers who brought in medicines from home to hospital and then hide them from the nurses. While you are giving medicines to these patients neh? - hospital medicines, there is that one which is hidden in the locker. The relative will come and give this medicine like for instance the whole mug of it, just because she will not be able to come at other times, like at night. Meaning that they in the process also give over-dosage here in hospital and there will be no difference in our treatment. While the hospital treatment was about to be effective, the condition suddenly changes and we won’t know that there is another type of medicine that is being given secretly.

| P3 |

I also want to add and complete what my two colleagues have said, as we try to heal the patient he gets this medicine from the traditional healer. After that he dies and we also wonder that this patient was coming all -right. We again have a problem with the same relative who brought the traditional medicine. Once the patient dies, she does not realize that what she brought to the patient is the one that created the problem. You find that now the relative suspects that we in hospital have done something because the last time she saw the patient, the condition was not so bad, meanwhile she is the one who created the problem by bringing this traditional medicine.
<table>
<thead>
<tr>
<th>R</th>
<th>Does anybody want to make further comments about your experiences as roleplayers in the health delivery landscape in Amathole District Municipality?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>We sometimes work with western trained people who are traditional healers. We experience problems with them too because they mix two things, the traditional healer and health professional. As the result you find that we don't click because they are encouraging traditional healing whereas in hospital they are supposed to encourage western professionalism</td>
</tr>
<tr>
<td>R</td>
<td>Encourage traditional healers. Can you explain that?</td>
</tr>
<tr>
<td>P1</td>
<td>They are encouraging people to go to the traditional healers. If somebody stays for some time in hospital and is not healing, she often advised that if you can go to a traditional healer, you can be better.</td>
</tr>
<tr>
<td>R</td>
<td>Now that the Act requires acceptance and recognition of traditional healers, will advising a person to go to a traditional healer be out of step?</td>
</tr>
<tr>
<td>P1</td>
<td>I don't think it will be out of step because they live in the community. They live with the traditional healers, so the only thing is just to advise them that if they are still on our hospital medicines, they must not go there until they are finished. The traditional healer needs to be educated as to which cases they are supposed to see and which to hand over to us.</td>
</tr>
<tr>
<td>P5</td>
<td>My experience with traditional healers is a bit different from that of my colleagues. Working in a psychiatric clinic we usually have patients brought by their families from traditional healers. Most of the times you find that they had come late for medication because they had started with traditional healers</td>
</tr>
<tr>
<td>R</td>
<td>You have mentioned that these patients were coming from traditional healers. How did you get to know that?</td>
</tr>
<tr>
<td>P5</td>
<td>Kaloku, these patients were brought by relatives and when you try and find out from them why Kaloku (bear in mind- my own)</td>
</tr>
</tbody>
</table>
did they come so late, they will state that they started with traditional healers. We also had patients who do come and say they have been referred by traditional healers to come to us for medication. The relatives tell you they want the patient to be stabilized, that is to take away that violent behaviour so that they can be able to give their herbs

R  So you are saying the traditional healers send these patients to you to be stabilized for violent behaviour and then?

P5  Most of the time patients who come to us for stabilization, we are aware our medication is not a cure to them, but to keep them healthy as long as they keep taking the medication. So what you hear from the family is that they will be taking the patient back to the traditional healer. It’s only that the patient at the present moment is unmanageable. They can’t cope with the patient

R  But now, why is it that the patient is taken back to the traditional healer?

P5  Most of the mentally disturbed patients you find that the community, the people, family, relatives, they always associate mental illness with a culture related thing, not something that requires western medication. So it is their belief that the patient is taken to us to be stabilized and then taken to the traditional healers where they are sure that they will be cured

R  So they are sure that the traditional healers will cure the patient?

P6  That’s what you always hear from the relatives. You find that the belief is that this thing, mental disturbance, is culture related. That’s why they believe that traditional healers are the best to cure it

R  Culture related, can you explain what you mean?

P6  When I say cultural related I mean it is something… some of these patients for example will say that they are suffering from “amafufunyana” which is a term they use for
mentally disturbed cases. They say the patient is suffering from a Xhosa syndrome so the relatives take the patient to the traditional healers because he cannot be cured with the western medication

<table>
<thead>
<tr>
<th>R</th>
<th>I am struggling to understand exactly what you mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>P6</td>
<td>Ja, you always find out that, yes, they bring the patient for western medication but at the back of their minds they know that for the cure, when we talk about the cure we mean for the patient to be back 100% healthy, they need to be taken back to the traditional healers. Ours is just to stabilize the condition. We are able to take away the violent and aggressive behaviour of a patient and make sure that they are forced to take the medication. They choose to come here. Otherwise most of the conditions that come here are such things like depression “ukukhathazeka”. But there are patients who come here we don’t know what has caused the condition. That’s where relatives believe that it is culturally related</td>
</tr>
<tr>
<td>R</td>
<td>So if you give medication to that patient and he goes back to the traditional healer, what next?</td>
</tr>
<tr>
<td>P6</td>
<td>Most of the time we do inform the relatives that if the patient comes to hospital every month to take his treatment, the patient will act normally in the community. So we usually encourage them that even if they go to the traditional healers, they must ensure that the patient must come back and get medication every month because at the end we are not sure of what is happening on the other side in the care of traditional healers</td>
</tr>
<tr>
<td>R</td>
<td>Am I interpreting you correctly if I say you are saying traditional healers send patients to you to stabilise? Do you at some stage also send the patients back to them and inform them that you have stabilised the patient?</td>
</tr>
</tbody>
</table>
Because I am a Xhosa person, sometimes I do come across patients and e-e-r I do also suggest because I grew up in rural areas and we have been following traditional healing. I do say “why don’t you go and see the traditional healer for this condition? For instance if a child has been sent to the psychiatric department suffering from what we call enuresis that is “ukuzichamela” I do suggest “why don’t you go and do something traditionally, culturally because this child might be needing traditional ritual that we call “imbeleko”. And sometimes when somebody is mentally disturbed and you sit down and try to interview the family and interview the patient and you can’t find anything that is possible for causing the patient to come, at the back of my mind I do think about something and talk to the family like this “did you try something? …..because I grew up in these communities

Do you then expect other western trained health practitioners to advise their patients to go to traditional healers?

Yes and no, because I can’t say anybody can refer. What I am thinking of is somebody with an understanding of these things

By these things you mean?

By these things I mean when you talk about mental illness and the conditions that are referred to us…. Some people don’t know about these things and they are coming from the western culture, so they can’t refer. It depends on who are you that is seeing the patient and what you understand about that condition

Am I interpreting the scenario correctly if I say to all of you your working relationship with traditional health practitioners was confined to the patients you shared and not on interaction with traditional health practitioners as such?

Almost all nodding
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>Now that there is this new Act on traditional healing, how is this going to affect your practice as western trained health practitioners?</td>
</tr>
<tr>
<td><strong>P2</strong></td>
<td>I think now that there is this Act, traditional healers will be sort of following civilization, so they may lose their clients to us</td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>Secondly the traditional healers don't want to divulge information which they have, because it has been given by the ancestors but now they are going to be forced to share the information with us</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>You see I am glad that there is this Act so that traditional healers are not looked down upon, because we have a tendency of looking down upon them as health professionals. Meanwhile traditional healers have something special but like among us as well there are people from nowhere who practice so that they can get money. But there are experts. They know one another.</td>
</tr>
<tr>
<td><strong>P4</strong></td>
<td>You know when this subject of the Traditional Health Practitioners Act was talked about, the idea that some traditional healers had, was that, they were going to be allowed to have a consulting room in the clinic where he or she could see the clients after a client had been seen maybe by a nurse. They were hoping that this client would be referred to them or the client would be seen by them and then referred. They were hoping that they were going to serve in the same environment as doctors and nurses</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>You know I personally would go for that</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>I am noting that you are focusing on the impact that this Act will have on traditional health practitioners but my question is on the impact of this Act on your practice as allopathic health practitioners</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>If you remember initially as nurses, we used to have a negative attitude towards traditional healers. Like I think somebody mentioned this earlier, for example a mother has gone to</td>
</tr>
</tbody>
</table>
somebody with her baby and had an enema then you would quarrel with that mother but really it was that mother’s choice to take the baby to wherever she wanted, but now working together and sharing information with these people, they give us what they know, what they are doing. We also give them information on what we are doing so that at the end of the day we can better off the health of the person. For example if I had to tell the traditional healer that the baby who is dehydrated will have such and such signs and if you prefer to give an enema, the baby will be loosing more fluid, he must be aware of that and then now if at least he is aware of that he can instead use home rehydration solution. Really health professionals used to undermine these traditional healers before and undermine their practice. I think as people who are working, they must also be considered as people who are part of the health team, because we rely on their help. We cannot deal with some of the issues. I know I’ve just mentioned the problem that we have with TB and HIV and there is drug abuse. They must know about these things and must also give us the herbs that they use and the purpose for their use. I think they will share that information. It’s only because that we were despising them or not respecting them but if now we can come to the table and discuss these issues, they can come up with them and we share whatever information they have

<table>
<thead>
<tr>
<th>R</th>
<th>I see</th>
</tr>
</thead>
<tbody>
<tr>
<td>P3</td>
<td>Firstly I want to state that we need to work hand in hand now that there is this Act as both traditional and western trained health professionals are working towards healing of the people.</td>
</tr>
<tr>
<td>R</td>
<td>Can you explain what working hand in hand entails?</td>
</tr>
<tr>
<td>P3</td>
<td>E-er what I have in mind is that by working hand in hand, they need to refer back that is the western healers to the traditional healers</td>
</tr>
<tr>
<td>R</td>
<td>What will the patient be referred back for? I did not get that.</td>
</tr>
<tr>
<td>P3</td>
<td>I think there will be good relationships between traditional healers and western trained people. We will be able to work together in that traditional healers will refer the patient to the doctor and after the patient has been treated by the doctor, the patient will be referred back to the traditional healer explaining all what has been given to the patient and when the patient should come back. In that way there will be no more conflict between the western and traditional healers</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>R</td>
<td>Was there conflict between the two groups?</td>
</tr>
<tr>
<td>P3</td>
<td>Conflict, at times yes, in that when the patient is admitted and is on treatment, now the family members because they feel they still need the traditional treatment, they bring the medicine to hospital. This was mentioned earlier. But now there will be no more...what?...because now they know that the patient will be discharged and will be referred back, so they can wait for the patient to be discharged and then the traditional healer will have his chance.</td>
</tr>
<tr>
<td>R</td>
<td>I am not sure if I get the impact that this Act will have on you as an allopathic health practitioner</td>
</tr>
<tr>
<td>P3</td>
<td>I think it will assist me in that, the attitude I always had against traditional healers, I'll change my attitude towards the traditional healers</td>
</tr>
<tr>
<td>R</td>
<td>The attitude. What are you saying about the attitude?</td>
</tr>
<tr>
<td>P3</td>
<td>Before legalization I had an attitude because at the institution where I worked as a professional nurse, nurses would absent themselves for about 5 days and would mention that they were ill with amafufunyana and had gone to a traditional healer for treatment. Unfortunately the traditional healer did not give sick certificate. This was disrupting our off duties</td>
</tr>
<tr>
<td>R</td>
<td>Were you having this attitude towards the nurses or towards the traditional healers? I am not clear about what was causing this attitude.</td>
</tr>
<tr>
<td>P3</td>
<td>I was negative to both. Sometimes a nurse maybe she is on training will be said to have amafufunyana, the traditional healer says so,</td>
</tr>
</tbody>
</table>
and the amafulunya turn out to be a pregnancy. My grandmother became deaf after being treated by the Sangomas, long before I became a nurse. So I became negative to everything associated with sangomas

| P4 | Can I interject? I think health professionals will try and work hand in hand with traditional healers in this manner: If the patient has been referred by the traditional healer, some of the traditional healers don’t have enough education to understand what has been written by the doctor or nurse. I think then we need to call the traditional healer to the hospital before the discharge of the patient if the patient relies on that traditional healer. If the patient was admitted being dehydrated, the traditional healer must be told that he has given a strong medicine, so he has to decrease the amount. I am not sure but it must be a somewhat arrangement |
| R | I am imagining the feasibility of this arrangement as some traditional healers may be as far away as KwaZulu-Natal |
| P2 | People! on my side I can’t imagine myself giving a patient a letter to the traditional healer because we are different in our working methods. I cannot imagine myself giving a letter to the patient to give to the traditional healer. He can’t read? |
| R | But there are traditional health practitioners who are professionals in various fields and even graduates. |
| P2 | Emphatically It’s going to be funny to send a patient out of hospital to a traditional healer who does not have equipment like x-rays. They have the herbs but will not see what is the source of the patient’s condition. Like when the patient is in hospital maybe she had gone to the traditional healer with headache and the traditional healer had given the treatment for headache. Here in the professional practice a client can go home without any treatment because we sit with the patient and find out that the problem is at home. We end up not giving anything, we advise and educate the client. The traditional healer has no time to educate the client so what must I now
write him about? The patient started with the traditional healer. The traditional healer could not stop the headache and the patient came to hospital, he came to us, so why must I again write to the healer. His part is over.

<table>
<thead>
<tr>
<th>R</th>
<th>Mhm</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>Another thing imagine we … I am a nurse. As health professionals this Act I think we have a problem here. The Act is binding us with traditional healers meanwhile we have a Council that controls us</td>
</tr>
<tr>
<td>R</td>
<td>Controls, in which way?</td>
</tr>
<tr>
<td>P2</td>
<td>Whow &quot;lo mntu&quot;(this person!- my own interpretation) referring to the researcher</td>
</tr>
<tr>
<td>R</td>
<td>Reclining back on her chair and obviously not prepared to elaborate</td>
</tr>
<tr>
<td>P5</td>
<td>Firstly I think we, health professionals are a barrier to working together. We do have a negative attitude and ask a person, why did you go to the traditional healers? Why didn’t you come to the hospital? Can you see now how you look like? So that is why patients at times do not speak the truth. I think we must start to correct there.</td>
</tr>
<tr>
<td>R</td>
<td>Mhm</td>
</tr>
<tr>
<td>P6</td>
<td>In the psychiatric services we have Health Awareness Days. We do go to the communities and talk to the community, giving health education talks, and these people, the traditional healers are also in the community they are part of the community. They become aware of the services we have. We tell the people that maan, there is another way of helping mentally ill patients. We tell them that we do give treatment, we stabilize. We say we know that there are Sangomas who also deal with these patients, but unfortunately we can’t accommodate them with us, but what we want</td>
</tr>
</tbody>
</table>
you people to do, instead of endangering the patient by putting ropes around their arms and legs, please try and bring these patients as soon as possible, early to the mental health services for medication

| R | You have mentioned your being unable to accommodate them, can you explain what you mean by that? |
| P6 | Yes, we have to be open and say that because we have already seen patients brought by families with sores around the feet, arms and ribs because he was seen by the traditional healer and was tied trying to force him to take medication. So what we are doing in these health education talks, we want them to be aware that the psychiatric service is here and we want them to come closer to us and work with us. We do have an interest in that because at the end these people, that is, the community, do use the traditional healers. That is why we want them not to take a long time before they bring the patient to us. You see if I can make an example of cases brought to us dehydrated, you see, didn’t drink anything for a long time because he was seen by a traditional healer. So to try and save them we want that relationship with them so that they can bring these patients to us not hide them. Because immediately we show that we are against the traditional healers, you will find that our patients will run away from us and say these guys are taking away our culture, something like that. |

| At this juncture we were disturbed by a nurse who was coming from OPD where there was an emergency requesting equipment for putting up a drip. The researcher had to temporarily switch off the tape to allow one of the participants to attend to that nurse |

<p>| R | Mhm. I’m listening |
| P2 | I am supporting this last speaker who mentioned awareness days. We must have awareness campaigns where we will tell the traditional healers that we won’t be able to send patients to them. Maybe they will understand when we speak to them. As a nurse I will not be able to send to a traditional healer a patient who did not even start there because maybe she does not even believe in traditional healers, she believes in hospital care so what am I promoting as a nurse? |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P5</strong></td>
<td>But because there is this Act, let me make this example. In some cases we can’t send them back to traditional healers but in other cases we have to send them back like let’s go to the issue of circumcision. Because when the initiate goes out of the hospital, let’s say he was admitted for whatever, we are forced to send him back to the traditional healers. In that case the ball does not end with us. I am saying it all depends because the circumcised has to go back to the traditional healer</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Look guys, in this hospital, when a doctor sees that the patient is not getting better from what he is suffering, he contacts another doctor in a bigger hospital like CMH or Frere where there are more doctors and specialists. That is why we are encouraging that traditional healers to know each other so that when a person sees that no, my client is not getting better, that there is another traditional healer who knows better than him then refers the patient to him. These are the issues that can be discussed in the Awareness Campaigns. I think traditional healers have a problem in that they don’t want to appear as if another traditional healer is more knowledgeable than himself. We therefore have to emphasize in those awareness campaigns that when you send a person to another healer, it is not that you are saying you know nothing, it is only that we differ in expertise</td>
</tr>
<tr>
<td><strong>P3</strong></td>
<td>To add to what my colleague has just said. In the past, traditional healers used to know each other, but jealousy or greed crept in and they tended to make themselves things that they were not, because traditional healers used to know that there were those who were specializing in divination, some in conducting cultural rituals. So when you go to the one specializing in cultural rituals like dealing with the “river” wanting divination, the healer would refer you to a diviner. So we wish for a similar arrangement</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Did you say they have since stopped referring to other colleagues? Why, if I may ask?</td>
</tr>
</tbody>
</table>

"river" (excess water in the body-term commonly used by the Xhosas to refer to a person who easily becomes swollen)
| P3 | What makes them not to refer to one another is the money. It is this money that they are fighting for. The problem is that if this healer refers to another traditional healer the client will tell other people that it is useless to go to so and so. I went to him but he referred me to another traditional healer and I got helped there. And now all people will want to go to the recommended one. So professional doctors don’t work in that way. Whereas they are all doctors with the same number of year’s training, but they know that if they can’t help the patient, they must refer to another doctor with more expertise |
| P1 | My suggestion would be that because traditional healers specialization is different, I think we need to do these awareness campaigns according to groups because these people are different. In the Traditional Birth Attendants group, yes they do deliver but now many people deliver in hospitals, but at the same time there are places where not even cars can go. I want to refer to those people. When we have those Awareness Campaigns, educate them about the transmission of diseases, cleanliness during delivery or supply them with things that they can use in delivery to avoid problems. We won’t be able to say they must not deliver in that area where cars cannot reach, or if they do reach by the time the car reaches the place, the woman has already delivered. In these places we need to provide them with something to prevent the spread of diseases |
| P2 | You know what I was thinking of? There are radios and TVs that can be used to make the public aware of these things, taking into consideration of course the lifestyle of each community. There also need to be workshops attended by both professionals and traditional healers where traditional healers will be informed about the diseases and how to avoid transmitting them from other clients to other clients and to themselves, so they also need training about the Act itself |
| P5 | I think they need to have their different skills |
sharpened like a traditional surgeon be trained to do circumcision perfectly, traditional birth attendants be able to deliver thoroughly but we won’t be able to train the diviners and maybe the herbalists too but they can be taught things like using measurement in the medicines that they use. They must not just pour medicine and say “drink” There must be time schedules like if I give you this bottle of medicine, it must last 2 weeks like in hospital' Their herbal medication must also be stored properly like in a friedge so as not to become stale

R  Mhm

P  My understanding of collaboration is that we need to work together, to cooperate. I am thinking of a situation where if it is a facility, the traditional healer will also be accommodated in that facility, where there would be a referral system for the client that means a nurse working in a facility would be able to refer a client and also the traditional health practitioner in the same institution would be able to refer a client to the nurse and they would work in collaboration and with the diseases that we have we will not make a confusion to the client. That means if the disease presents with signs and symptoms, the same nurse and the same traditional healer will have the same knowledge of those signs and symptoms so that they talk the same language to the client and even the client can see that these people are working together because there is one thing that is for sure, that we black people, we really depend, we really honour these traditional healers, because it’s part of our culture. That is something we cannot run away from especially if we are talking rural people and the rural people are the people that are giving us problems. Most of them are very far from the health facilities, the nearest people that are nearer to them are the traditional healers, so I think we must try by all means to go down to the traditional healers, meet them talk to them, go down to their level.

R  Somebody mentioned training, can you elaborate on that?
As you all know that most of these traditional healers are not well learned people but it’s through culture that they are in that situation. Now as a department, now we have a role to play, to train these people. Their training must just be at their level so that it is not a complicated issue, for example talking about this baby with diarrhea, I think even the traditional healer can be provided with a specimen of how to prepare a home made rehydration solution so that they even have a bottle with measurement on how to prepare it. I think this can work very well because the training will be at their level.

I think to promote liaison between traditional healers and western trained doctors and nurses there needs to be a medical center where all the types of traditional healers like traditional birth attendants, traditional surgeons and diviners practice so that we can have identified members from the hospitals to monitor there so that those healers get used to medical issues. The purpose of this center should be to train them and see that this training is done properly. I think this can eliminate the number of people who claim to be traditional healers while they are not.

Can I have clarity on the training that you are talking about? Who provides this training?

To me they have to be taught by western trained health professionals so that they become advanced in their work. We are not taking their job but we are making them advanced, They must know that to promote health they must do this but we won’t take them out of their own ways because if we take them out of their own ways, we won’t see them again. I think we can have these training centers at district level.

Mhm

To add on what my colleague has said, I agree that health professionals must provide training.
for the traditional healers. The Department of Health has to develop a curriculum and then a programme worked out based on that curriculum. The provincial and National Department of Health can put up a tender so that they get relevant people to conduct that training.

<table>
<thead>
<tr>
<th>R</th>
<th>OK, so it's the traditional health practitioners who need to be trained.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>You are raising a good point, Sisi because by collaboration, we mean sharing. There are things that these two health professionals must share so that there is no confusion on our clients. We must more or less speak the same language and the client must see that we are working together as a health team. So we must not display any confusion to our clients. Each one will learn from each other, whenever we are dealing with a client. It is important to realize that with our traditional healers it's a culture, it's a culture of the black people and the traditional healers are the people who are respected in their communities, people believe in them, so now as a nurse who has been trained in these institutions we must also understand the culture of our people. I think now in the curriculum even for the professional health workers it must be included that they must understand the cultural issues because they really affect the health delivery system in our society.</td>
</tr>
<tr>
<td>P1</td>
<td>For me Nom….., I don't think we should start with training and training centers. As a starting point we need to have meetings between the western trained people who are treating patients with western medication and the traditional healers. Meetings will be a way of understanding between them, what the others are doing and what the other side is doing, so that we can plan together. Take for instance what my colleague mentioned earlier about that mentally ill patient. If the patient is violent and</td>
</tr>
</tbody>
</table>

Mentions the name of her colleague
aggressive and hearing voices, on the western side they will say the patient is being psychotic but traditional healers will say he is suffering from amafufunyane. The signs and symptoms of mental disturbance are the same but they differ when they diagnose and they differ on how they are going to treat the particular patient.

<table>
<thead>
<tr>
<th>R</th>
<th>So?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>What I am suggesting, the best strategy to work together between the western people and the traditional healers is to continue having meetings. I’m saying let us work together with those traditional healers. Let us talk to them. Let us try and understand one another. Let us invite them to work together, let’s have a meeting maybe in a community hall where we can have questions, hearing from this person to that person and then we answer, we clarify things.</td>
</tr>
<tr>
<td>R</td>
<td>I am not sure if I understand what the meetings will be about</td>
</tr>
<tr>
<td>P1</td>
<td>You see the discussion, the elaboration about everything regarding how are they working, and we try and inform them about how we are working so that we can have a direction together because what I am saying these sick people will go and see the traditional healers, so let’s work together and understand one another. When we talk, what I am saying, we can come up with an understanding of one another. We will be talking openly and address common problems. They may for instance come up and say we’ve got a problem with you western people with one, two and three. Why are you doing this and how can we solve it? I am aware that the level of understanding can differ, but I can tell you the traditional healers know what they are doing, but language can be a problem with some of the western trained people, but we can interpret for one another. What is important is that we must have a goal</td>
</tr>
<tr>
<td>R</td>
<td>You were saying something about a goal</td>
</tr>
<tr>
<td>P1</td>
<td>Yes, the goal I am talking about is the goal of giving quality care to the patients. So the only way of doing that is sharing information.</td>
</tr>
</tbody>
</table>
Because at the end we want to help a patient. At the present moment we are confusing the patient, because if the traditional healer says do not go to the western trained healers for this and the western trained say do not go to the traditional healers for this. That thing at the end confuses the patient and the patient might not know how to use the two systems and will run to the other side while his illness needs another side.

If we can sit together with traditional healers who claim and say I can cure something, you have to give them a patient and make sure you do a follow up on that patient and find the results. That’s also what I am encouraging.

You see, the problem with…. I would like to say Xhosas, I am also a Xhosa, is that there are no studies that have been done, that have been connected with the cultural rituals. You find that in other provinces like KwaZulu, the Zulus have done research on traditional healers not the Xhosas. What I am trying to say is that there should be a study, we need to follow up a patient and see how a patient is getting well from a traditional healer. That’s the only way we can understand what is happening. With the western side they see the patient, they do a follow up to their medication and see the results of their medication. That is what is lacking with traditional healers. No one has done a follow up on their medication and on their way of dealing with the patient. So if we can sit down listen to their claims of being able to cure a condition, we can allow them to take a patient, see what has been done, see the results.

Earlier, somebody mentioned that you don’t know the methods used by traditional healers. Are you now going to be comfortable to entrust that healer with a patient that has been entrusted to your care?
<table>
<thead>
<tr>
<th><strong>P6</strong></th>
<th>I understand your concern but that is the only way in which we can come up with something from the traditional healers. Whereas we can feel we are taking a risk with the patient’s life, these patients have already taken a risk by presenting themselves to us and then to the traditional healers. At least now through our follow up we will know what has happened.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P3</strong></td>
<td>What uSisi is asking about risking with the patient’s life reminds me of our Council, if that will be acceptable with our Nursing Council. Usisi is a respectful way of referring to the researcher.</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>No! the Councils should start now to open their eyes, try to understand and try to change. I mean they must get good understanding of traditional healers because we do believe that people do go to traditional healers. The Councils should not be like a stumbling block. Emphatically.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>A stumbling block?</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>Yes. I mean with their laws and regulations that say don’t do this do that. Maybe the Council can punish us for working with traditional healers.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>OK let us proceed.</td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>You know, working with traditional healers, it’s easy with traditional surgeons, traditional birth attendants and herbalists but diviners are difficult. They work with ancestors, they work at another level. You can go and train as a herbalist. Somebody can tell you that when you want to cure, you use this and that. With the diviners who are the pillars of the traditional rituals-cultural beliefs of the Xhosas, it is difficult because that particular somebody is directed by ancestors. We need to look specifically at doing something for the diviners as they have that leg of the ancestors which we don’t know because they get their power from them.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>What should be your working relationship with diviners?</td>
</tr>
<tr>
<td><strong>P1</strong></td>
<td>Personally I don’t think I know. Shrugging her shoulders.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Remember we are discussing the mechanisms that can be instituted to promote liaison between traditional and allopathic health practitioners.</td>
</tr>
<tr>
<td>Can we proceed?</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td><strong>P2</strong></td>
<td>What I would like to share is that I would like to see western trained people trying to respect these traditional healers. I know they believe that the medication coming from traditional healers need to be tested, but we’ve got a problem of knowing that these people due to the help of the ancestors, they sleep, they dream and they are told go and take this and this and combine it and make medication with it. So sometimes it won’t be easy for them to come out straight with these medications.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>I’m listening</td>
</tr>
<tr>
<td><strong>P6</strong></td>
<td>And on the other hand we know very well that they say the western people will take their medication, test it and develop another treatment and then think they are the best in treating certain conditions, whereas they got the combination of the medication from traditional healers. So that’s why I am saying in connection with the medication we need to take a stand of trying to respect them. They have been doing these things for years. We need to know that this thing is better cured this side and this thing that side. For instance if we can talk about enuresis, giving treatment for a long time whereas on the other side this thing could be done over a day or two days through a traditional ritual. That is why I was also talking about the research.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Mhm</td>
</tr>
<tr>
<td><strong>P2</strong></td>
<td>At the present moment for instance we cannot treat cancer. We just stabilize and at the same time we hear that people suffer from cancer and are advised to see a traditional healer and that person is cured, but unfortunately because we have not done research, we have no statistics, no record. Now if we could ask the people to come out, not the traditional healers and hear from the people that “I was about to be amputated, somebody advised me to go to the traditional healer and I was cured.”</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>So?</td>
</tr>
<tr>
<td>P2</td>
<td>People should speak out and stand for what the traditional healers have done for them. The western side keeps records. If we can hear and believe in people who have been helped by traditional healers as there is no record. People should come with their stories, we record their stories that I was suffering from this and that and I was cured by this. We start recording from there.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>R</td>
<td>Mhm</td>
</tr>
<tr>
<td>P2</td>
<td>What I am emphasizing is that there is no written record so the best record we have in the communities are the people who have been helped by the traditional healers. For instance I know of a woman back at home when I was growing up when doctors had given up and said a person would never have children, but that woman would make what is called “ukumisela”(literally, to make a person stop but actually meaning to make one conceive). So these are the things. We could start counting how many people consulted that lady. The people doctors had given up by saying they would never have babies. If we could just make an announcement and say people must come with conditions that have been treated by traditional healers</td>
</tr>
<tr>
<td>R</td>
<td>Mhm</td>
</tr>
<tr>
<td>P6</td>
<td>I think this thing of legalizing traditional healers is long overdue. I think it is good that we are now going to discuss as health professional cultural related treatments. We can even introduce these studies to students so that they can be aware of these things. They need to be made aware of these things and they can also share their experiences of with traditional healers back at home before they were admitted as student doctors and student nurses</td>
</tr>
<tr>
<td>R</td>
<td>What did you suggest we must do?</td>
</tr>
<tr>
<td>P6</td>
<td>I mean things like it would be important for student nurses and student doctors during their practical period, they can start collecting information they come across which is culture related which is related to traditional healers. It is worse nowadays because they are doing what is called community based education.</td>
</tr>
</tbody>
</table>
They do go to the communities, especially nurses as they are key figures in health

<table>
<thead>
<tr>
<th>R</th>
<th>Can somebody summarize our discussion regarding the mechanisms that should be instituted to promote collaboration between allopathic and traditional health practitioners?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P5</td>
<td>Sasa, can you do it for us?</td>
</tr>
<tr>
<td>P1</td>
<td>Why me? You know I am not a good speaker.</td>
</tr>
</tbody>
</table>

| R | All right, I'll summarize what I think you have highlighted in our discussion and you are free to correct me if I have not interpreted your statements correctly. Most of you mentioned that you did not meet and work with traditional healers as such, but you dealt with patients presenting with complications after having consulted traditional healers. You stated that traditional healers were using unsterile equipment and unsterile herbs. They were not measuring the strengths of traditional medicines and medicines were given for an indefinite time. Pertaining to the effect that this Act will have on your practice, some of you indicated that you had neither seen nor read the Act, but the anticipation that the Act will change your attitude towards traditional healers did come up. You then suggested that to facilitate collaboration between traditional and allopathic health practitioners, you needed to understand each other. Having meetings and awareness campaigns would strengthen understanding regarding your working methods and diseases that could be handled by each side, as well as frustration that each side was causing to the other side. You also came up with the issue of training for both groups. Training for allopathic health practitioners related to culture and workshopping on types of herbs used by traditional healers and inclusion of traditional healing in the curriculum of both student nurses and student medical doctors. For traditional healers, elementary information on disease prevention, hygiene, sterility and use of measurements when prescribing drugs could be provided was suggested. You also raised the |
issue of testing the properties of drugs used by
the traditional healers as well as research on
claims made by traditional healers regarding
their ability to cure certain conditions. Cross
referral of patients also came up although there
was no consensus on this issue.
I am not sure if I have captured all you wanted
to share.

| P5 | You know something crossed my mind as you
were talking. I am thinking of the many health
facilities like hospitals and clinics that we have
around. An arrangement could be made for
Traditional health practitioners to tour these in
their geographical areas so that they can have
an idea of what is going on there, what doctors
and nurses do and the machines used that help
to diagnose a patient. Health professionals too
need to know how traditional healers are
working but the problem is that with the
traditional healers I don't think they have got
facilities like health facilities because most of
them operate at their homes. I don't know how it
can be done |

| R  | How what can be done? I did’nt catch that |

| P  | For instance, if they had a centre from which
they were operating, western trained people
would also take a tour and have sort of
orientation on how traditional healers were
practicing |

| R  | Mhm |

| P  | But I am not sure about this because for
instance at times you hear that traditional
healers get herbs from their ancestors while
asleep. They dream of a particular herb. They
are told go and take that herb and use it for
such and such a thing. I am not sure now with
this collaboration whether they will be keen you
know, to tell all, to give all the information about
the herb as they may be scared that the
ancestors you know will quarrel with them. |
| **P** | I think this act will benefit our society because we are the people who really believe in our culture. We believe in traditional healers. There are things that really give problems, so working with these traditional healers, the traditional healers will know the programme why it has to be done and will help us to relay the message to the older people who are the custodians of our culture. I think for the benefit of the people they must work together at facility level, work together at LSA level at community level. There must be those committees. They must conduct meetings together and come up with all the problems. I'm looking at the culture where initiates have been dying but since now the Department came together with traditional healers there is now more or less a decline in the deaths of the initiates, so really traditional healers must be involved in the health sector. They must integrate their services so that each one must know what is going on with other services so that when they deal with a client there is no confusion. One must know what is happening on the other side. |
| **R** | Do you feel we have exhausted all what you wanted to share? Anyone with another idea of how we can promote collaboration between these two groups? |
| **P** | No |

Laughing

Some looking at their watches
INDIVIDUAL INTERVIEW

GROUP 1A: COMPLEMENTARY GROUP OF ALLOPATHIC HEALTH PRACTITIONERS

DATE: 11.10.2006
TIME: 10h15-11h00

CONTEXT

PHYSICAL SETTING

- Interview was conducted in an office in the workplace of the participant
- There were some disturbances caused by a maintenance team that was making minor repairs.

THE PARTICIPANT

- The participant is a married coloured registered nurse residing in an urban area
- Has worked in a Trauma Unit and psychiatric hospital attending to patients from different racial groups including blacks.

Key:-
R =Researcher
P =Participant

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Can you share your experience as a western trained health practitioner practicing your profession in the health care delivery landscape in the Amathole District Municipality. How were your working relationships with other health practitioners including traditional health practitioners?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>I worked as a nurse in the Trauma Unit following which I was a manager in a psychiatric hospital. My</td>
<td></td>
</tr>
</tbody>
</table>
experience in the Trauma Unit was that the belief in traditional practitioner and his powers of being able to heal was great. I came from Uitenhage which is part of the Mandela Metropolitan. Cases that we used to see were mainly patients with conditions such as hypertension, cardiac failure and epilepsy. One thing that I found quite interesting and that I never could understand was the fact that people with hypertension and cardiac failure specifically, used to go to these traditional practitioners and would come back with cuts in their legs and the explanation given was that these incisions were made to get rid of the amafufunyana.

R  I didn’t get what you were saying about the amafufunyana

P  They used to present …..when they came being out of control of blood pressure if they were cardiac failure they came with severe oedema of the lower limbs, shortness of breath and so on, and they normally came after trying these medicines, that is the muti that was given to them, and then eventually coming with incisions accompanied by the family members because the muti does not work, it could not cure what they attributed to an illness they called amafufunyana. I really don’t know what that is but they usually said so.

R  After attending to the patient who was initially treated by the traditional healer, what was your next move?
That was long before the Act was passed and there was really no interaction between us being western trained people and traditional health practitioners. We discouraged at that time, the going to traditional healers and we gave extensive health education to our patients and make them understand what the illness was all about and that without treatment it could have lead to death.

Another thing that used to frustrate me as a nurse was when I saw a patient coming in with an amputated finger and the explanation used to be, we get fits and the sangoma had said if you amputate the finger, the fits will go away and that was something that was quite widely practiced. There are many black people or traditional African people that walk around with amputated fingers. I did mention earlier that being a professional and coming from a different cultural background, traditional healing to me was something far and something that was unacceptable because from what I viewed initially, it was seeing all these patients coming to us after being there and coming to us in a very bad state.

However through my growth and development within the health system and service, I have gained I think cultural understanding and tolerance and respect for the belief of others and therefore I am now of the view that we should not discard traditional healers out there and sort of blockage them, but we should rather view them as becoming partners because of cultural beliefs.
they can play a major role in assisting us with issues such as health education and promotion of health.

R  Should this traditional medicine be reserved for black patients only?

P  It depends on your cultural belief because traditional medicine is practiced by diverse cultures in South Africa and in the Indian culture for example you have Ayurvedic which can also be regarded as traditional medicine and a lot of people not being black do Ayurvedic. Also, another type of traditional medicine is homeopathy which is based on all the old boererate and a lot of people believe in homeopathy, whether they are Africans, it does not matter where they come from. Another new thing that is coming into play now and is also a form of traditional medicine, is acupuncture which is a Chinese or eastern origin and I must say I do go for acupuncture from time to time.

R  If we can go back to something that you mentioned earlier, did I hear you properly if I say you said you were discouraging patients from consulting traditional healers?

P  I definitely said so because we could even inform and confront the family by telling them to look at the state of the condition that their relative was in. There was no real understanding and there was absolutely no form of interaction between us and the traditional healers.
<table>
<thead>
<tr>
<th>R</th>
<th>Did you have any particular reason for discouraging them to start with traditional healers or go back to them after consulting allopathic health practitioners?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>One of the main reasons was that whenever we saw patients who started there, they came to hospital in a state where we had to do extensive interventions to reverse the condition, but if they had come for help earlier, we might have been able to intervene in a different manner, less expensive, less time consuming and less traumatic to the patient</td>
</tr>
<tr>
<td>R</td>
<td>In your opinion what mechanisms do you think should be instituted to promote cooperation between traditional and allopathic health practitioners?</td>
</tr>
</tbody>
</table>
| P | My view is that we should try and include traditional health practitioners in our health planning that we do in the province. That will, I feel ..will enhance the service that they could render towards improving the health of our population. We have a number of platforms that we as allopathic health practitioners have that we need to integrate with other sectors for example the intergovernmental relations forum that we have at district level and maybe looking at inco-operating traditional health practitioners on our District Health Advisory Council as well as our District Health Council, getting them involved in issues like health promotion, where we could look at having a training course for traditional practitioners training them on basic diagnostic skills to enlighten them with regard to signs and symptoms of common illnesses such as diabetes, hypertension, TB, HIV & AIDS so that they also will be
able to refer appropriately to allopathic health practitioners and I do believe that there is a place in society especially in terms cultural belief for traditional health practitioners and so therefore instead of antagonizing them, we should actually bring them on board to become part of our health team.

<table>
<thead>
<tr>
<th>R</th>
<th>You said something about a course for traditional healers</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>I think it would be wonderful if we could have a formalized standardised course, where we could actually issue them with certificates that say they had undergone a basic diagnostic course.</td>
</tr>
<tr>
<td>R</td>
<td>Are you suggesting that all types of traditional health practitioners should undertake this course?</td>
</tr>
<tr>
<td>P</td>
<td>In my opinion, yes, to ensure that their practice is up straight and also to eliminate what we mentioned earlier, that is people going to them for treatment and actually coming to western medicine being in the worst state than they would have been had they started off at an allopathic institutions</td>
</tr>
<tr>
<td>R</td>
<td>Mhm</td>
</tr>
<tr>
<td>P</td>
<td>And then also one thing that I feel should be done is that traditional healers should be encouraged to bring their muti for testing so that pharmaceutical experts can determine whether that muti is harmful or whether it could actually be beneficial and enhance treatment because in many instances, the muti that is being used</td>
</tr>
</tbody>
</table>
is old traditional medicine that is not only used in black cultures, it’s like in the old times we used to call it boererate and in most cases it’s the same things that are being used, it’s just that maybe in the African culture it’s named differently.

R  | I am noticing your focus on what should be done to or for traditional health practitioner, is there nothing that has to be done for allopathic health practitioners to promote collaboration between them and traditional health practitioners?

P  | I don’t know, I think because of the type of work that I have progressed to do, but my view is that the Act should be something that is taught within our western medicine and nursing schools to create an understanding within all our practitioners and future practitioners that traditional health practitioners is not to disqualify the medicine that we practice. It’s rather to fulfill a need within that cultural community that they serve. Also in terms of the existing practitioners who are already qualified, it might be necessary to have a sensitization campaign and arrange things such as workshops where western trained practitioners interact with traditional healers so that we can gain better understanding as health workers so that alternative forms of medicine are used.

R  | What would that interaction entail?

P  | I would imagine that it would be useful to have discussions. I don’t know if traditional healers would be open to that because many of their practices they
regard as sacred and sort of secret, and they may not be willing to share what they do, what muti they prepare and how they prepare these muti

<table>
<thead>
<tr>
<th>R</th>
<th>Why do you think they may not be willing to share?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>From talking to people, you know you get professional jealousy even among traditional healers and when you talk to people they say that sangoma is a good sangoma, that muti that he gives works and that’s why they are skeptical to share their practices with others for fear that other people may become as popular as they are and this is linked with money. Linked with money, can you explain that?</td>
</tr>
<tr>
<td>P</td>
<td>The thing is, if a traditional healer is popular it means more people will be consulting him and therefore more money will be coming in.</td>
</tr>
<tr>
<td>R</td>
<td>I am still listening to your views of the various ways in which collaboration can be done.</td>
</tr>
<tr>
<td>P</td>
<td>In my limited encounter with the actual healers except through the patients I think the two groups need to come together. Of course there are differences, but what is common is patients that need to be treated. If community wellness is the end result of us all there has to collaboration.</td>
</tr>
<tr>
<td>R</td>
<td>What differences are you referring to?</td>
</tr>
<tr>
<td>P</td>
<td>I think I am implying the fact that the western trained are more inclined to reveal that they are using evidence-based things that have to be trialed, tested and practiced and show scientifically that they are working, with limitations of course. But traditional medicine cannot state that. They say the ancestors...</td>
</tr>
</tbody>
</table>
decide upon issues like medicines to be given and so forth. There is no scientific evidence. It's a belief system that cannot be discounted as untrue or unworthy. People still use them and there are stories of success and worth.

<table>
<thead>
<tr>
<th>R</th>
<th>Mhmm</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>I don’t know whether I am contradicting myself but I am talking here systems that use different people and tools. A doctor uses a stethoscope, BP machine x-rays, traditional healers are said to be using bones and bees but at the end of the day, a person has to be well.</td>
</tr>
<tr>
<td>R</td>
<td>So?</td>
</tr>
<tr>
<td>P</td>
<td>So we have to start somewhere in collaborating. We have to because in any case patients do need the two systems.</td>
</tr>
<tr>
<td>R</td>
<td>You feel we must start somewhere?</td>
</tr>
<tr>
<td>P</td>
<td>I think at the national level through a clear policy to apply without anyone discredited for previous wrongdoing. Let the policy come down to where services are at community level.</td>
</tr>
<tr>
<td>R</td>
<td>What should be contained in that policy?</td>
</tr>
<tr>
<td>P</td>
<td>Let experts who are knowledgeable about traditional healing assist in drafting the policy, personally I have limited knowledge on those issues.</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>P</td>
<td>Mam, I'm done. I can't think of anything more.</td>
</tr>
<tr>
<td>R</td>
<td>Well, thank you so much, I may call you if there is something that I am not clear about when I transcribe this interview at home.</td>
</tr>
</tbody>
</table>
INDIVIDUAL INTERVIEW

GROUP 2 PARTICIPANT: TRADITIONAL HEALTH PRACTITIONER (DIVINER)

DATE: 11 NOVEMBER 2005
TIME: 16H30-17H45

CONTEXT

PHYSICAL SETTING

- Interview was conducted in a suburb of a small town in a big modern four bedroom home
- A very neat home with no signs that it belongs to a traditional healer

THE PARTICIPANT

- The participant is married with two children
- There is a family history of a traditional healer (his father’s elder brother’s son)
- The participant had undergone training as a traditional healer under the mentorship of a fully-fledged traditional healer
- The duration of that training was 5 years
- The participant did not wear any clothing or beads that suggested that he was a traditional healer.
<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Ndiyagamagusha apha eMa…….(Researcher mentions clan name)</td>
</tr>
<tr>
<td>P</td>
<td>Camagu Mama</td>
</tr>
<tr>
<td>R</td>
<td>Njengoko benditembisile ukuba ndizakukhe ndikundwendwele ukhe undinabisele ngendlela obukade usebenzisana ngayo nabanyanga ngokwasemzini kwakunye noogxa bakho abanyanga ngokwemveli. Ingaba ibikhona into ebikudibanisa nabanyanga ngokwaseNtshona?</td>
</tr>
<tr>
<td>P</td>
<td>Andizokuthi ikhona into ebindidibanisa nabanyanga ngokwesiLungu, kodwa njengokuba ndinyanga nje ngoku ndisebenzisana naba banyanga ngokwesiLungu, ndifumanisa into yokuba ezi zinto zinonxibelelwano, kuba uyakwazi ukufumana umntu encanyiwe zii allopatic health practitioners selede wa penshiniswa, njengoko ndinaye umguli onjalo. Selepenshinile ebhodiwe by a panel of doctors, experts too, ezilocal. Wabe ke umzimba lo wakhe ubolile wonke and lo mntu engasadibani naye notata wekhaya ngoba ebole bhutyu nangaphantsi zizilonda. Njengokuba ndithetha nje ngoku nawe unomntwana osele esekritshi kuba kwafumaniseka into yokuba i diagnosis ephume apha kwii allopatic practitioners ayikho right. Wathi ke akungena kwii rituals ezinentwaso, ezi thwasa related waske waphila umntu.</td>
</tr>
<tr>
<td>R</td>
<td>Mmh</td>
</tr>
<tr>
<td>P</td>
<td>Ndithetha ukuthi uphiile loo mntu njengokuba sithetha nje.</td>
</tr>
<tr>
<td>R</td>
<td>Mandibuze ke lo mntu uza apha kuwe sukuba esuka phi ethunyelwa ngubani?</td>
</tr>
<tr>
<td>P</td>
<td>Abanye bayeza being directed by their ancestors, but umntu afike</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>engazazi ukuba udirekhthelwa ntonina. Aze ezicingela ukuba mna inoba ndi well connected locally ndinoba nolwazi lomntu onako ukumnceda ngee herbs, izinto ezinjalo.</strong></td>
<td><strong>Andiqinisekanga ukuba ndikuva kakuhle. Njengokuba usithu umntu uza esithi udirekhtwa zii ancestors, yena ufika athi kwenzeke ntoni kuye?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mná ndis'mke ke ngoku ndahlala naye phantsi ndamxelela iproblems zakhe; uneengozi ezimehlelayo and is wasting a lot of money. Izinto zakhe zi upside down.</strong></td>
</tr>
<tr>
<td><strong>Mmh</strong></td>
<td><strong>He-e okokuba well connected kwakho uminisha ntoni lo mntu?</strong></td>
</tr>
<tr>
<td><strong>Mná ndis'mke ke ngoku ndahlala naye phantsi ndamxelela iproblems zakhe; uneengozi ezimehlelayo and is wasting a lot of money. Izinto zakhe zi upside down.</strong></td>
<td><strong>Ufika kaloku enengcinga yokuba ndizakumcebisa ngabantu ab local abanolwazi lwamayeza esiXhosa. Kaloku mna undazi nditaya (wearing a tie-researcher’s interpretation) njengokuba naye etaya. Ndis'mke ke mna ndimvumisele, ndimxilonge ndibone ezo problems zakhe.</strong></td>
</tr>
<tr>
<td><strong>So kukho abo beza ngolo hlobo. Abanye?</strong></td>
<td><strong>Abanye njengokuba beyi one beyi two abo bebezile, athi akubona apha kuye ukuba hey impilo yam intle ggithangoku, axelele abanye. I’ve got umzekelo. A CEO from kwenyi i Province ethumele abantu more than five. Bathi xa bendifowunela ndibuze ukuba nifuna ntoni kum? Bathi “hayi sibone lo uphambi kwethu. Akunakuze umenze abemhle abe nje kangaka kanti thina akuzeokuwazi ukusinceda. She is not the only one oriferishileyo. Endimsebenzileyo yena makes it appoint that uthumela abantu apha kum qha. Yes!</strong></td>
</tr>
<tr>
<td><strong>Ndikuva kakuhle. Ingaba ke mhlawumbi akukhe kubekho othunyelwa nguggira okanye unesi?</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>R</td>
<td>So, wean le diagnosis uyibone ngokweSintu?</td>
</tr>
<tr>
<td>P</td>
<td>Definitely, Laa mntu ebenida itraditional handling qha, kuba okwakubola komzimba had nothing to do nezaa cream ebezisebenziza egqiba iMedical Aid yakhe eyi exhausta. In short abariferishi oogqira but thina siyareferisha kubo. Thina we sit down, asibuzi thina kumguli ukuba uva ntoni na. We sit down and then invite our ancestors zikubonise ukuba ithinina iiproblem. Then umxelele umntu ukuba nazi iiproblems zakho and ukhuphe idiagnosis, uprescribhe wenze whatever ritual.</td>
</tr>
<tr>
<td>R</td>
<td>So, as umguli ehleli apha phambi kwakho, you make that connection with your ancestors. I wonder njani bethu?</td>
</tr>
<tr>
<td>P</td>
<td>Uyazi invayitha ngokunqula. Yes. Ndingayi samarayiza ngokuthi it is through mystical powers that a traditional healer is able to diagnose and prescribe, through mystical powers. Yes, and then the ancestors…..they play a major role and then ukuba uyambona ukuba lo mntu unida ireferral, siyamreferisha thina but the allopathic health practitioners don’t refer to traditional health practitioners at all.</td>
</tr>
<tr>
<td>R</td>
<td>Ke ngoku kwelakho icala ukhe urifere kwenzinye inyangi zemveli?</td>
</tr>
<tr>
<td>P</td>
<td>At the moment andikabinayo icase ekhe indoyisele ukuba ndiyiriferishe. Andikabinayo okwangoku. Andinakuthi xa inokuthi ibekho andinakuyiriferisha kumntu mhlawumbi ospeshiyalayize kwinto endingenayo, but so far ndisakwazi ukuzihandlisha ezi cases</td>
</tr>
</tbody>
</table>
zize kum.

R  Kungokuba kwelakho icala uspeshiyalayize ngantoni?


R  Like what? Andikukhetshi kakhule.

P  Like all the thwasa related rituals into ezifana nemfukamo, intatha bhekile nembeleko. That is my area of specialisation.

R  Mhmm


R  Oogxa bakho bona bakhe bariferishe kuwe?

P  Baninzi. Kungecawa namhlanje.Izolo oku njengokuba , bendisebenza enext door ekhaya, emva kwemini I had a series of appointments, abantu abeza kem bezokuncedwa ngamayeza, befuna ukunceda iiipatients zabo.

R  Utsho abantu abakwangoogxa bakho?

P  Ewe, abakwangoogxa bam, abathi bazazi ukuba baqhwalela kuliphi na icala. Bekwazi nje ukuxilonga nokuvumisa, bazazi ukuba bayaqhwalela kweli cala leyeza. Bayeza kum.

R  Kweyakho ingcinga ingathi kutheni oogqira noonesi bengathameli nje bona apha kwelicala lenu lakwaNtu?

P  Le question yereferral ingathi ineqhinga xa ndiyijonga. Uyabona into endiyibona ingathi ifuna ukwenziwa nayiDepartment le, ifuna iiitraditional health practitioners ukuziginya neh? Zisebenzele ezibhedleleni. Uyabona ke yikho loo nto. I’ve got indawo

**R**

So ucinga ukuba yintoni ebangela ukuba bangakhe bona bathumele kweli cala lakwaNtu?

**P**

Isizathu they are still looking disparagingly kwizinto ezinobugqira phakathi. Kwabaninzi ayikangeni le nto. Ayikangeni. Kangangokuba ebekhona uggqira oreleted apha kum u late kodwa ngoku. Ndada ndamcela ke yena. Kukho le nto ye breach of confidentiality. Le patient bendisithi yayingasalali notata wekhaya ndaya kuyo ndathi “jonga ndiyakucela Mabani ndifuna uku khonvinsa lo gqira. Ndicela ke ndikukowute ndimxelele ndithi lo wayebhodishiwe yi panel yoogqira, but mna ndimnyange waready ukubuyela kwimainstream yomsebenzi. Asikho esinye isizathu endisibonayo other than that they are looking disparagingly kwitraditional healing. Nangoku they are rebelling against the Act.

**R**

In your experience akukhange udibane noogqira okanye oonesi abazisebenzisayo iiservices zabanyanga ngokwemveli?

**P**

Baninzi kuba akhona namanesi azitradiitional healers. Ndisandula uku enroll(a) ngoku abangoo sister. Bayayazi ukuba le nto isebenzisana njani, that is itradiitional healing ne allopathic and they do make use of opportunities kweli cala le traditional healing services ukuba imeko ifunisa oko. Bayenza ngolo hlobo bona. Sebe informed okanye mandithi sebengamagqira bayayirispektha into yertaditional healing.

**R**

Kutheni ke ngoku bengariferishi nje

**P**

Mandenze umzekelo ngonesi oyitraditional healer. Bakhona babini phaya eclinic e…. (mentions the place—but the researcher does not

<table>
<thead>
<tr>
<th>R</th>
<th>Ingathi ke sincokole ngendlele obukade usebenzisana ngayo nezinye iinyangi, makhe sigqithe kancinane ke ngoku. Lo mthetho ke ngoku ufuna ukuba kurhekhognayizwe itrational healing ingaba wean uwubona njani?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Umthetho lo wona ungena in the niche of time and ngokuqinisekileyo we have to applause its introduction because imajority yabantu bagula behamba. I majority is on wrong treatment. Kudayagnozwe wrong kanti aba Bantu kuzakufuneka bethunyelwe apha kuthi thina zitrational healers. Lo Government udizeva i pat on the back.</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>P</td>
<td>E-e-er itrational healing is here to stay. Abantu abaninzi ngabantu abagula behamba. Abaninzi bakwi wrong treatment. Umntu ade ayokubhubha ingakhange ifunyanwe i diagnosis kuba kweli cala le allopatic health practitioners abakwazi ukuthi I diagnosis abayifumani. Ingxaki ikuloo ndawo. Amgcine umntu emnika I diagnosis engeyilo. Athi akuza kuwe kufumaniseke ukuba le nto nantsi</td>
</tr>
<tr>
<td>R</td>
<td>Ndikumamele.</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>P</td>
<td>Lo mthetho umtsha ke ngoku comes in handy. Abantu bazakuncedakala ngokuqinisekileyo kuba ngoku ubanika ileeway abantu ukuba mabarejisterishe basebenze. Nam ndinikwe loo task yokubarejisterisha. Ndine database endiyiestablishayo, ndiyilinka nale ka Government so that kuzokwazi ukubakho izitructures okanye ii offices zokukwazi ukupromotha iCode of Conduct yonke loo nto. Kuba yiprofession lena in its own right ekufuneka ke izimele. Izakuzimela ke kuba lo mthetho sewuyivuma le nto. Uziyeke ii loopholes ezisekhoyo in its constitution ekusebusy zisasetyenzwa, kuba yonke into eqalwayo ibanazo ii loopholes. Kodwa okusalayo izitructures will be in line with the Constitution and ngoku izakuma icace irespekhtsheke into ye traditional healing. I'm currently occupied nabanye abalocal ukwenza loo database. Siyabarhejistarisha ngoku ootraditional healer, ukwenzela bazokungena basebenze ke ngoku umsebenzi ocacileyo with the norms and values zeConstitution, neAct yonk’into.</td>
</tr>
<tr>
<td>R</td>
<td>Ukhe wathi mention indaba yee loopholes.</td>
</tr>
<tr>
<td>P</td>
<td>Ewe zikhona iiparagraph ezikhona ezincinci ezifuna ukulungiswa. Xa kufreyimishwa into iqala from scratch ibabroad. Ibabroad to accommodate izinto eziliqela ezifunekayo. Well ayinangxaki ke loo nto because as time goes nee offices zi estabhlishekte, nedatabase ibe ikhona, zirejistarishile neenyangi, sizakwazi ke ngoku ukuba sifumane abantu who are operating above board ukuze ke ngoku kulungiswe kakuhle. Otherwise iframework yona isemcimbini kakuhle ngokuba iyayinika ileeway yokuba abantu basebenze. Ayenzi into yokuba makungaqhutyekekwa ukubheka phambili. Iquestion nje yeyokuba kulungiswe ukuba how can we accommodate iaspect ethile apha kwitraditional healing. Loo nto ke</td>
</tr>
</tbody>
</table>
ifuna I broad consultation kwelicala le traditional healing

R
Bendifuna kanye uphefumle apho uthi into ethile ukuba bekunokulungiswa yona.

P
In fact andizokukhumbula njengokuba ndithetha nje kuba iAct ndiyifunde ngoku ndisiza kule interview nje ukutshekisha ndizikhumbuza, ingasukuba ndiqwalasela into endinokuthi ndiyikowute. Unfortunately I am hamstrung.

R
Ndiphawula ukuba abthandazeli abakhankanywanga kulo mthetho. Lithini elakho kuloo nto?

P


R

P
Ok, njengokuba sithetha nje iitraditional healers zisayanyaniswe phaya kwa Department of Health kuba ke ikhona iproblem yee
resources ezingekhoyo right now especially iiresources zoku
establisha ii offices zokuthi put the necessary structures in place
and so on and so on.

R    Mhmm

P    Okusalayo iiitraditional healers zimele ukuba zizimele. Iitraditional
            healers belong kwi profession yetraditional healing, finish and klaar.
            That is not negotiable. Oogqira babhilonga kwicala labo. Loo nto is
            not negotiable. Yi question yokuba xa uyitraditional healer ubhideka
            uxakiwe, yirhiferishe kugqira. Nogqira bin turn must refer to a
            traditional healer. Kukusebenzisana okunokuba right ke oko. Not
            into yokuba kusetyenzelwe kwistrates zezibhedelele ngamagqira.
            Ayinjalo loo nto. Ngaphandle kokuba sistructure esakhelwe
            amagqira, yiclinic yamagqira, not ibe yiclinic kaggira kuba loo nto at
            the end of the day yenza kubeke ukudelekakhwenye iprofession.
            Ayizokusebenza ngolohlobo. Ndithetha ngento endiyaziyo
            endingafifuniseliyo apho ufumanis aukuba itraditional healer comes
            in handy apho oogqira iiexperts zoyisiweyo yinto ethile. Ezaa cases
            zimbini zamalady ebendikhe ndathetha ngazo, omnye ebhodishiwe
            by a panel of doctors ngoku uyabuyela emsebenzini uyokutitsha.
            Omnye bekuthiwe makakhuphe isibeleko. Ezo zinto convince
            nawuphina umntu beyond any reasonable doubt ukuba zizinto
            ezimbini ezahlukenyenyo.

R    Mhmm

P    Akafuni uggira ukuthi xa esoyiswa athi ndoyisiwe arhiferishe kum
            ndizokuyihendlisha loo nto, sibe thina sesiyenza loo nto already.
            Ukusebenzisana. Intsebenziswano ilapho apho ikhoyo.

R    Uggira kaloku uqhele ukurhiferisha komnye uggira, isejini okanye
            ipsychiatrist. Yintoni ke ngoku ezakumenza ukuba ariferishe
            kwitraditional healer?

P    Correct! Uggira uright ukuba azithi exhaust zonke ii avenues
            ezikuye at his disposal aqiniseke ukuba uyihambe yonke iroute
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>P</td>
<td>Mabafune ne opinion yetraditional healers kubaloo nto iyenzekahambe izezipecialists umntu</td>
</tr>
<tr>
<td>R</td>
<td>Bazakuyazi njani ukuba kukho itraditional healer engu So and So abanokuthumela kuyo ipatient?</td>
</tr>
<tr>
<td>P</td>
<td>I database ikhona right now. Njengangoku ndinamacard alapha kume kvufuneka ndiwadistribhuthe kwinyangi zemveli ezikule eziqula ndihlala kuyo kwaye ndiyabarejistarisha kuba I am one of the ….. members zalapha eBuffalo City. I database ikhona, seyikhona njengokuba ndithetha nje. Oogqira bafanele ukuba bayazi ukuba ikhona idatabase.</td>
</tr>
<tr>
<td>R</td>
<td>Ima ke kule database kuyaxelwa nantsi itraditional health practitioner engubani isebenza njengexhwele, igqira, njalo njalo?</td>
</tr>
<tr>
<td>P</td>
<td>Okwangoku ayikabikho loo nto ecacisa into yokuba……kaloku sise bhizi. Zezi zinto zizakulingiswa once iCouncil ibe in full swing operation because at the end of the day there has to be a Council eyenzelwe ukuba ezo zinto ibezizinto ezicacileyo. Kucace exactly ukuba this one specialises ngoluhlobo, ibe yinto ekhoyo e available phaya.</td>
</tr>
<tr>
<td>R</td>
<td>Utsho pha, phi?</td>
</tr>
<tr>
<td>P</td>
<td>Pha kwidatabase leya ikweziya offices zetraditional healers. Isayame kwi Department of Health right now.</td>
</tr>
<tr>
<td>R</td>
<td>Mandithi ke ndingulogqira, ndizakuyifumana njani loo information?</td>
</tr>
<tr>
<td>R</td>
<td>Is’ke ingathi nje ingamahum-hum nale nto yalomthetho mtsha apha kwinyangi zemveli?</td>
</tr>
</tbody>
</table>
**P** | OK, njengokuba benditshilo ndisithi siyabarejistarisha ngoku, kuba ubuggqira obu….e-e-r iiitraditional healers zinetendency of operating ezikoneni. Alright umthetho wona uthi noba usebenza kuloo kona yakho ilungile but kufuneka waziwe ubekhona kwidatabase. It is small wonder ke ngoku ukuba kubekho abangekayazi.

**R** | Kodwa ke kuzakufuneka ikho icampaign to concientise oogqira ukuba isituation imi ngoluhlobo. Xa mhlawumbi sizakulontsha idistrict structures apha eBuffalo City kuzakufuneka kubekho icampaign. Le campaign inceda iiitraditional healers ukuba zibe aware ukuba nantsi into isenzeka. Phaya we will not be targeting umntu osele erejistarishiwe ku target(hwa) nabanye ekusafuneka berhejistarishiwe abanokuthi barhejistarishwe ngale mini kuthiwa kuyalentshwa. Therefore ivigorous campaign inokwenziwa, but kuba le nto iqala andizokutsho ukuba for sure ezi zinto sezi in place. Zizinto ezisezakwenzeka, ukwenzeka kwazo ngoku zisenokwenzeka nokuba ku on a small scale. Basenokubakho abantu nakweliphi icala nokuba ngootraditional healer noba ngoogqira abangekho aware ukuba ithini na inkqubo ngokuphelelele. Yes!

**R** | Phofu ukurejistarisha oku yinto engenabunzima?

**P** | Bukhona ubunzima obukhoyo. That is for sure. Isizathu being that ubukhulu becala kweli cala leitraditional healers kudomineyithe ubukhulu becala I illiteracy, ukungakwazi ukutolika izinto ngendlela eyiyo. Right? Loo nto ke yenze iresistance. Bakhona abasebe informed. Even if bailliterate abakho illiterate kwelicala letraditional healing, ne exposure yokusoloko bephuma besiya komaBhayi, nasemaTranskei ibanika ukwazi ukuba yintoni elindelekileyo as a result once beve ukuba ndikhona ndiyarhejistarisha, bavele bazizole nje. Iresitance izakwenzeka of cause kubantu abangaqondiyo, kodwa ke ezi campaigns xa zilontshwa bazakude baqonde abantuukuba you cannot operate usebenze ungaziwa ungabikho
nakwi database ube umthetho usithi yaziwa xa uyinyangi yemveli. Kuvela kubelula kum ukuthi xa urhejistarisho mlawumbi eSwazini, le Act ithi explicitly xa ulapha uopereyitha you have to be governed by the norms, standards and values zalendawo and therefore you have to be registered, ubhilonge. Iyangena ke ebantwini nangoku sebebaninzi endibarhejistarishileyo, kodwa ke iyandiqoba kakhulu kuba ifuna ndisebenze kakhulu.

<table>
<thead>
<tr>
<th>R</th>
<th>Kwezakho iimbono, aba bangafuniyo ncam ukurhejistarisha inokuba yintoni?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Babethwa kukungaqondi. Xa uyijonga.le nto kaloku in the past iimali zabo bezityiwa kakhulu ngabantu who can be regarded as “fly by night”. Baqokelele imali nje ebantwini, kungabikho follow-up as’ke umuntu aduke. Ziicases eziliqela endidibene nazo ezo.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Ndimamele.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Ikhona enye into engandicaceliyo ncam malunga nendlela enilungiswa ngayo for ukunyanga nina zinyangi zakwaNtu.</th>
</tr>
</thead>
</table>

<p>| R | Xa usithi “isikolo” ingaba uthetha ngantoni, njani? |
| R | Sizakuzibona njani ke ngoku ezi zikolo njengokuba sisazi ukuba umntwana ofuna ukuba nguggira okanye unesi uzakuya kwi university yasekuthini? Ke ngoku ithini le nto xa sisithi sifuna intsebenziswa. |
| P | OK fine. Iinorms sezikhona right now kuba kwezinye iindawo…..Ikhona iworkshop ebekuyo. It was a national conference eMthatha on the 13,14,15 and 16 of October aphi iinteraction yayisenzeka kakhulu. Sasitatsha kanye izinto ezinjalo including iperiod. Mandithi focus kulendawo sikuyo. Thina we say our standpoint….asiyonto iphuma kum le, yiposition yantoni? yeAssociation. Ithi iperiod yetraining yomntu yiminimum ye 5 years and loo nto ireasonable enough ngokwezethu iinorms and values. Uyabona ke, once there are structures in place, kulula ukuyimonitharishna le nto yokuba aba bantu ngabantu nyhani abakhwalifayayo ukuba babenezikolo abaziestabhlishileyo na. Yinto esezakwenzeka leyo kodwa ke ngoku seriously ayikenzezi kuba kusajongwe ezi sezikhona zingarahedyuleyithwanga, zingajongwayo and so on. |
| R | Uyabona ke ngoku sitetha ngeistikolo ezifundisa abantu abathwasayo ubuggira. Now lo mthetho wetraditional healers uquka itraditional birth attendants, uquthethe ngeherbalists nethraditional surgeons, ingaba nabo kulindeleke ukuba bathi undergo itraining ye 5 years? |
| P | Ngamaggira la kufuneke ethe undergo itraining ye 5 years, amaxhwele wona andiqiniseki ngemeko yawo. Thina magqira we say this is the position of our Association-5 year training period. That is the minimum period and loo nto iyadiphenda ukuba iresources zikhona na. Isenokuba ngu 5 years as’ke omnye abe |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>engenazo iiresources zokuperform(a) iirituals. So ngumntu oneresources ezaneleyo oyakuthi acinge enze-minimum 5 years. Loo mntu ke angagрадyуweyitha akukho problem.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><strong>Uyabona ke ngoku we want to establish a link, icooporation between ootraditional healer naba banyanga ngokwaseNtshona. Singenzene njani?</strong></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td><strong>Elicaле letraditional healers have to move fast, libeke iistructures in place so that whatever information enidekayo ibe readily available. Right now iproblem isekhona kuba we are in the process of putting them in place, so that aba Bantu babe clearly identifiable-lo ulixhwele, lo uligqira, lo yisangoma trainee, lo yingcibi, kuba iroles and responsibilities zaba Bantu zohlukene, totally different njengokubza zidifferent ezepharmacists kwezw medical specialists. Therefore, traditional health practitioners have to move fast now that the Act iyavuma ukuba ezi structures zibe in place. Again le nto ixhomekeke nakwi co-operation ye Department of Health ngoba iiresources zisaphuma kwaHealth. Isekhona iproblem yokuba…..nangoku besine workshop after the national conference in Mthatha sibe nefollow up yezinto apho we have actually managed to put a programme. Iprogramme moss ihamba nebudget. Siyibekile sayithi thaca iprogramme yethu sikufanele, kuba akukabikho nto icacayo.</strong></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><strong>Ima ke, xa uthetha ngestructures ubhekisa entweni?</strong></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td><strong>ICouncil is there already so ndibhekisa kwi provincial structures, district structures, sub-regions.</strong></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><strong>Kwenzeka ntoni kwezi structures ingobani abaphaya?</strong></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td><strong>Ziitradiitional healers ezi zivunyiweyo ngumthetho. OK, apha eQonce kufanele kubeko hiistructures ezilqela, eAmathole ibe zii sub-regions ezilqela eziyokwenza iDistrict structures. Ke ngoku iapproach esiyisebenzisayo siqala ngeDistrict structures, then</strong></td>
</tr>
<tr>
<td>R</td>
<td>idistrict izale isub-structures ngokujonga into yokuba mangakanani na amanani, kube kukho mimimum ne maximum number efunekayo ukwenza istructure. Idistrict structure izakuthi yaku establisheka izale lula isub-structures. OK, makhe sibuyele kulaa question yeduration of training. There are people who are already operating out there having undergone itraining edifferent, abanye ngoo six months abanye about five years. Ithini ke ngoku into?</td>
</tr>
<tr>
<td>R</td>
<td>Xa sijonge ke lo mba we liaison or collaboration phakathi kweliqela lenu naba banyanga ngokwasemzini, you mentioned earlier i issue ye referral. What else can be done to strengthen this collaboration?</td>
</tr>
<tr>
<td>P</td>
<td>OK, besiyimenshinile ne issue ye professional preparation engalinganiyo. On the whole intsebenziswano currently isenokuba yiproblem enku. Kuba naleCouncil ye traditional healers ingekaestabhlishwa kunzima nento yokuba siyiconsidarhishe seriously nale issue of referrals, kuba laa council kaloku once it is</td>
</tr>
</tbody>
</table>
there kuzakubakho neCode of Conduct and iCouncil knows exactly what to do and what not to do. linformation ikhona phaya kwidatabase. Zizinto ezizakukwazi ukwenzeka nokuba kukho loo campaign yazise ukuba nazi iispecialists kwifield ethile. Zizinto ezinokwenzeka once the Council is in full swing operation. Currently ikhona iproblem kuba kunzima xa ufike inyangi seyinesikolo, kufuneka uqiniseke ukuba iyakhwalifaya na ngokupheleleleyo. Yha, kuba ayikenzenke ivigorous screening yecurrent schools now that the Council is not yet there.

**R**

Otherwise kwezakho iimbono inokuthiwani njani le ntsebenziswano xa siyibeka ecaleni le yeCouncil into. Ingaba ezi group zimbini zeenyangi kufuneka zisebenzisane njani?

**P**

Ndikhe ndive kukhalwa nge intergration. I question of intergration yona, let'sforget about it. These are parallel lines intokunayo ke ngoku yiqueston yokuba ziparallel nje makuphuculwe elicala ngestuctures and offices ekufuneka ziestablishishwe in line with the Act and Directives ezikhoyo izokwazi ukuthi ihambe smooth. Nangoku kuseright njengokuba isathiwe nca phaya kwaHealth nje kuba kaloku ayikabikho in full swing operation le nto ye traditional healing ngokwecala lokuba established, apho besizakuvela sithi for sure why don’t you make referrals.

**R**

What is your idea ngale intergration ubuthetha ngayo?

**P**

Ingxaki yeyokuba ezi ziisystems ezimbini ezisebenza differently neh? Kwelicala le traditional healing kudomineyitha iquestion yezinyanya apho zikunika i instruction yokuba sebenza ngoluhlobo, right? In line with norms and values zazo. Kwelicala lingapha basebenza ngokutshekisha idiagnosis, bamnike umntu iyeza eselikhona, iiprescriptions zikhona, ii pharmacists zikhona, yaye njengokuba zisebenza parallel nje yeyona ndlela iright leyo kuba akufunekanga enye iprofession iyidelele enye, because zii professions ezimbini ezahlukenuyelo ekufuneka zizimele ngolohlobo.
<table>
<thead>
<tr>
<th>R</th>
<th>Ukuba besisithi makwenzeke i intergration besiyakuba sithetha ntoni kanye?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Ingathi uthi I role yetraditional healers ibalulekile, kutheni iservices zetraditional healers zityelwa ekhusini nje?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Iproulem isuka kude. Utthe akufika umlungu apha wasiqhatha. We were a close-knit society. Ootatomkhulu behlutha benabafazi abaninzi, kungekho problem niks, bekhonsentreiythe ekwenzeni izinto zakwaNtu-well-knit society. Uyazibona ezi zinto zooNongqawuse zonke yayizizstrateji zabantu abamhlopho ekusiphamisedeni imindset yethu. Za estabhlisha neemissionary institutions, kwatolikwa izinto rhongo. AbeLungu bafika baphazamisa neculture yethu yokuhlala, bezama ukuzisa eyabo iculture noxa bengakhange bayikhuphe bayithengise ngokupheleleyo. Nangoku isekho iproulem kuba bambahla abantu abayaziyo iculture yabeLungu ukuba ihamba kanjani. Ndayibona</td>
</tr>
</tbody>
</table>
Iculture yabo ukuba OK, njengokuba thina ngoku sisithi sihleli isilungu, siyabhideka, kuba lo mLungu uvele wasusa laa ntu iyilaa culture yethu iphucukileyo yenza ukuba izinto zethu zithi qoko, wezisa eyakhe aphinde wayiqhobosha akayikhupha ngokupheleleyo. Mna as a scholar ndiyirhisetshile le ntu ndabona ukuba tyhini abasazenzi ngako iiirituals zabo abeLungu. Phaya eCumakala ndibona ngenye imini kuphekwe ngeembiza zesiXhosa phaya phandle. Ndibuze kwi domestic yaphaya ukuba kwenzeka ntoni na, ithi kucelelewa intombi yela khaya engendiyo umyeni, icedelwa umyeni


<table>
<thead>
<tr>
<th>R</th>
<th>Ke ngoku njengokuba ningalamacala mabini kungaright ukuba elicala lilifundise ngokupheleleleyo izinto zalo eliya?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Into efunekayo xa ndiyijonga mna le nto, thina sesiyazi inti esimelwe kukuyenza, nesiynzayo yokurhiferisha. Bona abkho aware. Kufuneka ilungiswe le nto ye referral zi structures ezi zibekwa in place kwaziwe ukuba yinto emelwe kukwenziwa njani. Lelicala letraditional healers ekufuneka likhonshethayizwe (concientise) kakhulu ngaloo nto. Ne database le yakugqitywa kumelwe kwensiwe iicampaigns koogqira bakhonshethayizwe ukuba this is the situation. Izakwazi ke ngoku ukusebenza kakuhle ngolo hlobo.</td>
</tr>
<tr>
<td>R</td>
<td>OK, ke ngoku kwi way of operation zikhona izinto elingathi eli cala sizakuzifunda kweliya nelinye lithi sizakufunda oku?</td>
</tr>
<tr>
<td>P</td>
<td>Masiyivume into yokuba zikhona izinto elicala le traditional healing ekufuneka lizikope kweliya cala. For instance, i Ethical Code of Conduct is already there kubo, kufuneka siyazi ukuba oogqira baziphatha njani. Nathi si opareyithe above board ngokuziphatha ngokwe Ethical Code efremishiweyo.</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
</tbody>
</table>

| R | Ndimamele |
| P | Mandithi ke iacquisition of that skill is through mystical powers. Ixhomekeke ekubeni abantu bakowenu bakuthanda kangakanani na. kuba abanye bayakwazi ukuthetha apha kuwe ezindlebeni, kuthiwe uliligqira elinomathetha entungo, abantu abadalala |

| R | Nomye umntu eve ukuba ingathi kukho into ethethayo? |
| P | Bathethe, sukuthi ingathi. Bathethe bakuxelele ukuba inje into. Okwesibini, ulele, bakubonise ipicture yalento okanye yalemvumisa |

R

Ewe.

P


R

Mhmm

P

Sikunika iadvanced skills of how to interpret dreas so that uzokukwazi ukumnika idirection umntu, uthi lithetha ukuthi, because abakhwetha kaloku bafika bengazi nokuba kubethwa abaphi. Sukuthi lihle eli phupha, ithi lithetha ukuthi nokuthi, because kufuneka yenziwe loo ritual lithetha yona. Undivile moss ngeliyaxesha besisancokola ukuba ndithe akukho nto bekufunekanye yenziwe kum ndingazange ndiyiboniswe emathongweni. Yonke into eyenziwe kum, kangangokuba uprincipal wam mna wathi
<table>
<thead>
<tr>
<th>R</th>
<th>Ndikumamele</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Wathi xa endigodusa endibeka enkundleni wathi ibengumhlola ukuba nomkhwetha ohammad no informed ngoluhlobo. Bendisebenza ngezazkills zokunika….when you have to give a critical analysis yento ethile. Istyle neline uyazi ukuba kwa iplacement yegama isymbolayiza ntoni. Yiprofession le yasesikolweni, eza zinto ziya applyala nalapha. Kangangokuba ungayihlekaninkosikazi apa endlini, akukho thongo ingakwaziyo ukulitolika. Uyayibona itrick ukuba indawoni na. attach the correct meaning kule dream. Yile nto ke kufuneka iimentors ezikwaziyo ukwenza a critical analysis.</td>
</tr>
<tr>
<td>R</td>
<td>Ewe</td>
</tr>
<tr>
<td>R</td>
<td>Ndiyakuva. Ikhona mhlawumbi enye into ongathanda ukukhomenta ngayo enokunceda ekwenzeni intsebenziswano phakathi kwabanyanga ngokwasemzini nabanyanga ngokweSintu?</td>
</tr>
</tbody>
</table>
| P | Alright. Mna le nto ndiyijonge ndayijonga iculture le yomntu. It does not matter how many degrees one has, one has to stick to his culture, no matter what. Ukuba iculture yakho idimanda ukuba yenza ezi zinto, don’t hesitate. Akuthethi into yokuba ukwenza ezi zinto kukwenza ezokuthwasa qha, uyakwazi ukwenza amasiko nezithethe and so forth. Uyakwazi ukuthi after having done those rituals ugqithe ukuba uyathwasa, yenze loo nto because it is part of
Siyathanda ukuhamba simimikha ezinye izinto esingazaziyo noba zithi gqi phi na, umzekelo le culture yabelungu yokutaya. Uthi ukuba unxbile ufake itayi ube sesosicokovane. UNosimo une point kulento ayenzayo yokupromowutha l traditional dress attire. Jonga amaZulu, they stick kwiculture yawo and ayahlonipheka.

Ndizama ukwetyisa le ntetho yakho ndiyoyamise nalentsebenziswa nobu sibonisane ngayo ukuba engeniwa njani qha ndimana ndibhideka.

Lent’inje abantu phandlaphe bagula behamba. Yiproblem umuntu ogula ehamba

Mhmm

Iculture abantu mabayilandele benze nayiphina into ekufuneka beyenzile kuloo culture. Abantu mabangabi namjojo, banemijojo

Utsho ukwenza iculture njani ke?

Nayiphina into efuna ukwenziwa efana neerituals zakwaNtu ngokwe culture yakho. Ukwenza umzekelo neh? Uyabona ezazinto zokuba kukhatshwe ootata, zizinto ezibalulekileyo ezo kuba ababantu

Ngabo kanye ababakudirect(ayo). If uya ignorha ezazinto ukuzenza uzakuthwasa njani, ngoba bona ngoku abazokuthi reciprocate bakunike whatever you need kule line yokuthwasa xa ngaba wena akubahoyanga.

Xa ungajonganga skills zakuthwasa, what is the point yokwenza ezi rituals zifana nokukukhapha?

Ukungabakhaphi ootata ubabuyise awunazinyanya zikugayidayo zikubonise indlela. We need people who are mentally balanced.

Ndifuna uxukushe ikakhulu lo mba wentsebenziswa phakathi kwabanyanga ngokwakwaNtu nabanyanga ngokwasemzini
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Hayi ndiqobile ngu tyhini! Kunini ndithetha?</td>
</tr>
<tr>
<td>R</td>
<td>Mandibulele ke ngenxaxheba negalelo lakho kodwa ke ukuba ndithe sendisekhaya ndakhumbula into ndakufowuna.</td>
</tr>
<tr>
<td>P</td>
<td>With pleasure.</td>
</tr>
</tbody>
</table>
INDIVIDUAL INTERVIEW: – TRANSLATED FROM ISIXHOSA

GROUP 3: NURSE CUM TRADITIONAL HEALER

DATE: 16 JUNE 2005
TIME: 10H00- 11.30

CONTEXT

SETTING:
- The interview was conducted in a suburb in Buffalo City.
- The house is built on a sloppy area with steps leading from the street down to the house.
- Neighbours on both sides are white families.
- At the back of the house is a huge deep cliff with thick bushes and a river.

THE PARTICIPANT:
- The participant is a registered nurse, specializing as a diviner but also issues herbs/ treats patients.
- Is married, with three children, two already holding professional jobs while the last born is at tertiary.
- Her aunt had undergone the thwasa process but she has never seen her except in dreams.
- Though clad in ordinary clothes, the participant wore beaded ankle and wrist bangles and a beaded head gear
- As we met, the participant immediately asked me to follow her to the backyard where she greeted her invisible ancestors calling them by the clan names. She then humbly requested them to accept me in the household addressing me by my clan name

At this juncture, two hadedas appeared crossing the cliff, and she excitedly pointed out to them saying “Aah there they are, we can now go inside the house. So you are welcome.”

Key:-
R = Researcher
P = Participant

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
<th>COMMENTS &amp; NON-VERBAL RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>As a qualified nurse who is also a traditional healer can you share your experience as a stakeholder in the health care delivery landscape in the Amathole District before the Act that legalises traditional healers came into existence?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Thank you Ma, thanks Zotsho, first I want to formally introduce myself. I am MaDosini, Mphankomo born by Mandlovu and being a grandchild to the Nozulus, Mpafanes.</td>
<td>Zotsho is the researcher’s clan the participant is also</td>
</tr>
</tbody>
</table>
Before this Act I did not have that confidence of telling the person everything. Now I can tell him/her. Even the doctor does say to me “please come sister, speak to this patient.” So you can see the co-operation can be there but my concern is still that not all of us as traditional healers have certificates that confirm that they have completed their training.

R
OK, I am interested in the way you’ve been working together with other health practitioners in the community before the Act was even talked about

P
Oh! They did not even want to hear about us, we traditional healers. They used to say “you are too superstitious”

R
Who are “they” if I may ask?

P
My colleagues, nurses, but as time went on, they could see. Like there was a child with fits and he would even stick out his tongue. I said “leave this one to my care”. I saw that he was being called to undergo the thwasa process. I talked to his parents advising them. I advised them to do a certain Xhosa ritual. Indeed he became better. I told his parents that this child was “thwasaing” and has to follow all the rituals. First the cultural ones, not necessarily the ones for “thwasaing.” A person starts there. I gave him medicines, mentored him until he completed training.

R
Are you saying to me a person can become sick, only to find that she/he only needs cultural rites?

P
Exactly!

R
Let me go back to my question. You are a nurse this side, a traditional healer that side, how were your working relationships with your colleagues, that is, other traditional healers and other nurses or doctors?

P
When I was working in the hospital it used not to bother that much. My being a traditional healer used not to interfere that much but here in this Community Health Centre because there are all sorts of people, sometimes as I do physical examination of the patient, I have that feeling in my blood that this person does not need a doctor,
he/she needs a Xhosa cultural rite. I feel that in my blood, as I examine him. I even follow a person and call him aside and tell him, “please go to your people and ask them to take you to a diviner” not necessarily that they must come to me. I don’t grab them to come to me. A person must go home and tell his/her family that he/she has met somebody at the Health centre who advised him that he does not need hospital medicines, but he needs to go to the diviner to hear what is wrong with him.

R  Mhmm

P  As somebody who started in this Centre in 1997, the nurses gradually understood me. I invite them when I conduct my rituals at home and they begin to say “Man this person has long been like this. She is no chance-taker in traditional healing”

R  You are saying that they gradually understood you. Did they not understand you first?

P  By the way, to be a person with “white blood”, you don’t see things the way other people see them. Sometimes you just become irritable out of the blue, sometimes you don’t feel like talking, some days you don’t feel like greeting people. A person becomes amazed when you again laugh with him. You have to explain that “people you have to understand that I am a sick person.”

R  A sick person?

P  Yes, I mean I have undergone the “thwasa” process. A person must not take me otherwise. It is just that, that thing has come up

R  What thing has come up?

P  The feeling that says “no don’t talk, stay alone”

R  Did that situation have an effect on other people that you worked with?

P  Sometimes you could see that it could make you to be taken in bad light at work, but because now I have been there for years now since 1997, they eventually understood, through seeing that each time I tell them I come from somewhere, I am from the seclusion ritual, I come back as a different person. It became clear to them that really sister S….. has something

Quoting her
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>This understanding that you are saying exists now, is it with your colleagues the nurses, or doctors or patients?</td>
</tr>
<tr>
<td>P</td>
<td>It is there even with doctors. Even with my matron if I tell her that there is something that wants me to do this and that. Like one day that I came in limping, I told her that an elderly woman had come in my dreams and bumped against me. After that I went home to perform a ritual and I was healed having not taken a pill. She realised that this person is being handled by those down there</td>
</tr>
<tr>
<td></td>
<td>“Down there” pointing underground</td>
</tr>
<tr>
<td>R</td>
<td>So, were you saying even the doctors understand now.</td>
</tr>
<tr>
<td>P</td>
<td>Yes, the doctors too. An example now the doctors call me not because they want me to interpret for those who do not understand English, but are realising that this patient’s condition does not need western medical care, it needs Xhosa things. So the person who can give them direction is me</td>
</tr>
<tr>
<td>R</td>
<td>So the doctors were doing this even before the existence of this Act?</td>
</tr>
<tr>
<td>P</td>
<td>No, it’s when there were these talks that we traditional healers must be recognized</td>
</tr>
<tr>
<td>R</td>
<td>And before the Act?</td>
</tr>
<tr>
<td>P</td>
<td>They used to be fed up. Sometimes when I looked back I would find others back-biting me saying maybe she is being visited by a cheeky ancestor that does not want her to talk to people</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>P</td>
<td>And with patients? How were your relations with patients?</td>
</tr>
<tr>
<td>R</td>
<td>Because it’s not only this side of traditional healing that I have, I also have religious ancestors in so much that even if I’m walking in town, there are patients who call me saying “hey we did not get the prayers today. It showed that you were not there.” What I mean is that they are people who understand me. Sometimes while on duty, something tells me to sing the traditional song that says “the voices are coming in the morning” (oonomathotholo bayeza kusasa). You find</td>
</tr>
</tbody>
</table>
patients laughing. I tell them that today that ancestor that requires me to sing has come. Even if I was taking the patient’s blood pressure, I put down that stethoscope and baumanometer and stamp dance, stamp dance. Sometimes it comes out that the very patient I am attending to, at his home there is somebody who is a traditional healer.

P  Mhmm

R  But one day I remember, the doctor was looking for a nurse to interpret for him. The nurse he had sent to look for this interpreter, found me singing traditional songs and the patients assisting. The nurse said “the doctor is waiting for somebody to assist him” So I stamp danced and stamp danced until Dr O…. came himself and asked “why are you dancing when I am waiting for somebody to assist me?” I said “look doctor, if you can report me to Head Office that I am jiving, I can be expelled. I am not dancing, I am stamp dancing, because that feeling that says I must stamp dance has come, so when that thing is over, I will come”. I said “dancing and stamp dancing are two different things.” The doctor laughed and that nurse was disappointed because she thought the doctor was going to shout at me and report me.

R  Ok, Let us pass on a little bit. Now, here is this Act that requires recognition of traditional healers, how do you think this Act will affect your practice as a nurse and a traditional healer?

P  Since there is this Act, that requires us to look at people in all aspects, look at the person in totality, I found that very admirable and commendable that the Government requires us as nurses and doctors to recognise cultural beliefs. That has made nurses to call me for advice when they see a patient coming again and again for the same complaint. They now call me and say this one it seems he/she needs to be treated the Xhosa way. They call me secretly and I talk to the patient.

R  Is what you are saying something you wish for or something that is taking place?

P  It’s something that is happening that is also my wish because I have noticed that during this era of
HIV even if a person is being informed that he/she is HIV positive he does not believe or accept it and maintains that he/she is being called to undergo the “thwasa” process. It’s where I say, my child you are not “thwasaing” it’s just that you do not want to accept this diagnosis. Accept this illness because there are things that need medicine used by western trained people. That is where I, with my knowledge of both sides, I decide that a person should take hospital medicines or that this one really needs Xhosa rituals. This knowledge assists me to help the person.

<table>
<thead>
<tr>
<th>R</th>
<th>How do you see that this one needs cultural (Xhosa) rituals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>It’s automatic if you have been thoroughly trained because as somebody who has undergone the “thwasa” process with red ocre and white ocre, that has made me to be broadminded and possess what you call instincts in English. You just feel it in your body and establish whether it is psychological, you say no, a person cannot come now and again for the same illness, having been given treatment that usually helps other people but does not seem to help. No, it needs to be viewed the other way.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>As a nurse who observes that this person has been visiting the clinic repeatedly, don’t you think of referring him/her to other doctors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>That is where I assess and see that no this one needs an operation. He/she does not fall under the traditional side, but the person is a strong believer of Xhosa medicine even if something has to be treated in the western ways. That’s where I need to advise. I just want to make an example of somebody with fits. A person with fits cannot depend on traditional medicine. He must first take hospital medicine, so that we can see from his blood how the tablets are working. As he has fits repeatedly, is he taking the treatment correctly? We can draw blood specimen to see the blood levels of those tablets. He must not insist on traditional ways when the condition needs hospital treatment.</td>
</tr>
<tr>
<td>R</td>
<td>Mhmm</td>
</tr>
<tr>
<td>---</td>
<td>------</td>
</tr>
<tr>
<td>P</td>
<td>I think there is some advantage that this Act would make but it has a worrying part. It worries me. I want traditional healers not to be all regarded as traditional healers as long as a person does not have a certificate. The Government must impress that if a person says he/she is a traditional healer, that person must produce a certificate that shows that he/she has completed his/her training under a mentor. That traditional healer who was mentoring him/her must have proof that indeed this is my person that I have trained completely. I am confident that he can perform divination, he can treat patients and here is the certificate to that effect. Because we traditional healers are interpreted wrongly. As you approach people you can see people are unimpressed, because we are said to be visiting Gauteng to acquire snakes to make us successful healers. Then we have a bad name. I wish a traditional doctor who says he/she has completed training and maintains that he can treat a person could have a certificate so that if somebody came for consultation and the traditional healer ordered medicines and further observes that the patient needs an off from work, you are able to issue a sick certificate. I so wish that this Act is taken seriously. The traditional doctors should produce their certificates and not mislead people. By the way there is no doctor who can just make himself a doctor. It does not matter how good a person is. It’s compulsory that you are made to be a doctor by somebody else. A teacher has to be there to teach you, a mentor who must also have a certificate.</td>
</tr>
<tr>
<td>R</td>
<td>What certificate must a mentor have?</td>
</tr>
<tr>
<td>P</td>
<td>A certificate to say he is a fully trained traditional healer.</td>
</tr>
<tr>
<td>R</td>
<td>Are these certificates available?</td>
</tr>
<tr>
<td>P</td>
<td>I am worried because I have not seen them. My mentor, Mam….. is also looking forward to that. She has already returned home some of her trainees without certificates. You see if I could have a certificate I would request, now that I have a few years to retire, permission to establish my own surgery here. You can see moss that I have</td>
</tr>
</tbody>
</table>
**R** Returned home trainees, what does that mean?

**P** To return a trainee home is to hand him/her back to his/her family to state that you as a fully fledged traditional healer have trained him/her, he has completed training and is ready to treat patients

**R** Earlier on, you said this Act has some advantage.

**P** Exactly, because at the same time I am relieving the load for the hospital. I am avoiding people flocking there whereas they just need to be helped by me on the traditional side. It’s where I am going to see that this one needs ARVs. I will refer him/her because I don’t have them. The one that needs treatment for fits does not need a traditional medicine

**R** What kind of medicines will the surgery that you said you wished for have?

**P** Traditional and hospital medicine because I have these two sides; nursing and traditional healing. I am going to be a traditional doctor with a difference because of my training

**R** Just there, as you are mentioning these two sides. Do you feel that there is a need for co-operation or collaboration between these two groups of healers; the traditional healers and the western trained healers?

**P** The need is great. I so wish…. you know, I don’t know how we can do this, to have our own meetings as traditional healers, because I usually say I am not that keen on treating patients on the traditional side more than I wish to conduct in-service for traditional healers because I usually see a traditional healer carrying a root that he has dug from the soil grating this medicine. Why does he/she not start with washing the medicine, because in that soil there may be tetanus? Now he gives somebody a medicine that has been grated without….so I need to workshop traditional healers. That is my interest. So we come together as traditional healers and do right things, be clean and not take a medicine that has been standing there in a dirty container for some time and ask a
person to use it for washing. I wish not to be a traditional healer that treats, but to workshop other traditional healers. We traditional healers come together, get to know one another and know that we have different blessings/expertise. We must speak one language that we are here to help people.

R By the way if you workshop the traditional healers which issues are going to be dealt with?

P I want to workshop them on traditional healing issues because I have discovered that there is still a lot. Yes, we are gifted but we are not doing our thing right. We forget about health education. Even if you are making the skin incisions on a patient we tend to seal those incisions with our saliva. This saliva of yours, you don’t even know your HIV status. I wish to workshop them and say use gloves, use a blade and discard it and you don’t just throw it away because it has somebody’s blood. They need to know how to dispose these. I wish I could work that way.

R This function of work-shopping other traditional healers, do you wish to do it as an individual or is it something that you feel nurses who are traditional healers could be asked to perform?

P I wish I could workshop them while I am still in full employment. It is my personal wish. But I so wish we could call one another as traditional healers and educate ourselves about this Act, and use our traditional healing correctly and not be greedy for money. Those that we see that they don’t belong to us, we send them to the doctors, and not continue with somebody’s child whilst you see that he/she needs the attention of western trained doctors but you continue with Xhosa things.

R I wonder… if one sees that the patient needs western medical care why not refer him/her to western trained doctors?

P Mind you, these poor traditional healers, one is illiterate, he has never been to school, that’s all he has. To him it’s about gaining money. Now he is uneasy because if he refers this person to the medical doctors, he will not get that money, it will go to the medical doctor.

R At some stage you mentioned things that are
P

Yes, I am really concerned. You know by right according to my knowledge traditional healing is a pure thing, is white. I don’t see the reason why somebody who has come to this home to be mentored because she saw this man in her dreams, and ends up being a wife here, overtaking this man’s wife. She came here to be mentored on the “thwasa” process and must go back home having completed “thwasaing” and not having made filthy things. That woman or man who is mentoring this trainee must maintain purity.

R

I don’t think I understand you now.

P

Never mind Ma, I think it’s these irritating behaviours that some traditional healers display at times. It is like somebody’s child, I don’t see the reason, I am just making an example, a child who has been taking his bible and going to church, but now since coming from a circumcision school he is ever drunk. You cannot keep on drinking and drinking each tot of alcohol that you are served with. You can just pour your share in that tot on the ground and invoke your ancestors. Not each time the tot comes round you take it and drink it, you are an alcoholic of a traditional healer meanwhile you are treating other people’s children. Let’s do away with alcohol. That is another issue that I would like us to deal with as traditional healers.

R

So as a traditional healer who is a nurse you are also concerned about those issues relating to the practices of traditional healers, if I understand you properly.

P

Yes I am concerned about the blades that are used to incise people in the existence of this HIV that we are fighting. Those blades must not just be thrown away. There must be a way of disposing them. That medicine must also not be allowed to stand there for a long time but you keep on instructing the patient to use it without checking how clean it is. That is hygiene.

Even in those meetings that I mentioned earlier
on, I think the fully fledged traditional healers who are mentoring the trainees must be the ones who are invited to a meeting first. They must meet with the western trained doctors so that they discuss the issue of working together....that now we are working together. If a person is under my care as a traditional healer, I have a right of booking him/her off sick if his illness is such that he cannot go to work. He must not wait to be seen by a medical doctor for the sick certificate. Even myself if I have to go and conduct a ritual for somebody, as a nurse who is still employed sometimes I have to lie and say I am sick, meanwhile I am not sick. Now it has to be known that I have gone to conduct a ritual like to keep somebody in a seclusion grass hut. I must be given leave officially. I must not have to tell lies and say I am sick or I have a domestic problem. I must be given leave officially that says sister S..... is going to conduct a ritual for her trainee, so she will not be at work for so many days. So that leave has to be signed for and be given a name. I must not tell lies and say I am sick. The participant mentions the name

<table>
<thead>
<tr>
<th>R</th>
<th>Do you have to tell a lie now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Yes, I am forced to</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>So you are suggesting that this leave must have a name and not fall under one of the existing types of leave.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Yes, it has to be additional to the existing leave. So if I have a certificate you will know that I am not telling lies. I will have something that says on such and such a day I will be conducting rituals for so and so because here is my certificate, I am a traditional doctor with trainees, I have to attend a séance, maybe I have to assist another traditional doctor who is a mentor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>You have just mentioned that in the meetings that have to be called between traditional healers and medical doctors one of the issues that have to be discussed is the issue of working together/collaboration. What is your understanding of collaboration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>It has to do with understanding. It must be known and understood that I am also a traditional doctor who is supposed to be having her own surgery, consulting her patients at stated times</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>I would like you to fully explain what collaboration entails and how it can be promoted between traditional and western trained health practitioners</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>This is how I see working together; the sister who was consulting a patient sees the notes. This patient comes in now and again for the same problem. She must say now, OK let me call S…… This patient must be referred to her so that she can see if we are still right by treating her with western medicines or she needs traditional medicines. She must be referred to me by that nurse. I will also give feedback that no, really, I have also seen this patient. She does not belong to your side, she belongs to us traditional healers. The participant mentions her name.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>So that is the way you see working together/collaboration</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>To me that is the most important part of working together. I may think of other ways later. OK, other methods in which we can work together in hospital are that if the Government can allow me to use my traditional medicine here in hospital. I am going to give you an example. If I see that here is a patient, she has been in labour for quite some time, she does not deliver. I have a plan, I know that by mixing this and that, the patient just swallows the mixture and in no time, she delivers, but I can’t use those things because I have not been allowed to. That is another way of working together.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>So you want to be allowed as a nurse who is also a traditional healer to use this medicine that is only known by you in this patient?</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Yes, provided that I have the ability, I have people that I can show you and say this one I am going to make an experiment with her. I will make this mixture now and let her drink it in front of you, and you count the time it has taken for her to deliver without having to be referred for caesarian section.</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>I am now going to give you a few minutes to try and summarise these various mechanisms in which you said this collaboration can be promoted between these two groups of healers</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Regarding this collaboration it is my wish that the government allows us to have a place where we can register our certificates which shows that we have undergone training and completed it and we</td>
</tr>
</tbody>
</table>
are ready to treat people

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td><strong>When you say “we” who are you referring to?</strong></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td><strong>I mean we traditional healers</strong></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><strong>Silent</strong></td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>I was still saying, again if a person is seen now and again by the sister or doctor and he/she sees that now he/she does not become healed with my medicine the doctor must refer the patient to me. The Government must agree that in this institution where I work, this community health centre for example, if I see that I can help a person in whatever way, if I have a herb, allow me to display it in the dispensary. When a patient has been seen by me the prescription is there available. There could be somebody in the dispensary who is trained like myself. We also want to be given a chance to “preach” to the people, like I want to make an example about somebody at work. Here is a child, brought by his mother. The mother is bringing the child to the clinic because the child has diarrhoea. The mother has given him an enema using a traditional medicine meanwhile they are taught about the “mixture” in the clinic, you know. I stood there and preached and said “people, a person who can use a Xhosa medicine or who can drink a “baboon’s urine” is somebody who has been assisted by me as a traditional healer to conceive. This person has difficulty in getting babies, and she came to me and I said OK when you are about so many months pregnant, I will give you a traditional medicine to take (the baboon’s urine). I know when you deliver I will be there to attend to you.</td>
</tr>
<tr>
<td></td>
<td><strong>Preach is a term commonly used by Xhosas to refer to giving health education</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Baboon's urine is a traditional medicine that is said to quicken labour</strong></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>How do you know that this patient because you had given her a Xhosa medicine is going to be attended to by you when she delivers?</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>No, what I am trying to avoid is to see somebody who has been attending an “English” clinic saying she has taken a baboon’s urine whereas the nurse has not told her that. Now this “baboon’s urine” becomes something that people laugh at, something they entertain themselves with. But if it was something known that this client has been helped to conceive by such and such a traditional healer, the healer has monitored her. It’s the</td>
</tr>
<tr>
<td></td>
<td>“English clinic” refers to government clinic- clinic run by allopathic health practitioners</td>
</tr>
</tbody>
</table>
healer who has advised her to use the baboon’s urine for a certain duration from such and such a month. Even when she delivers the healer knows what she/he will do. These details must be known, I write them down as a traditional healer that so and so has been assisted by me to conceive. So as a traditional healer and a nurse I must have my foetoscope and baumanometer and monitor the well being of the baby, and know that when my client is in labour I am there. These are the things that I wish for in this collaboration.

**R**
I don’t think I have a clear scenario of what you have just explained. It is as if you expect your clients to come to you as a traditional healer from your neighbourhood. I was of the opinion that traditional healers deal with people coming for help from afar. How then do you expect to be there when she goes on labour? You had also indicated that some traditional healers are not educated. Do you expect them to fit in with these foetoscopes or you were having this wish for those who are traditional healers and nurse like yourself?

**P**
Uneducated as they are if they have travelled that road….It's what I have said earlier that I am confident with the place where I was healed (trained). I have no fears. I’ve gone through the whole process and was monitored. That is why I was saying it is my wish that we meet and hear other people's views, other traditional healers because I don’t know how they have been trained, how they have been healed. That is why I say I wish there could be a meeting of traditional healers, express our views because one is going to say I am not educated but in my dreams so and so appears, the one I am following in this thwasa process, she/he says I must do this and that. We cannot dispute what that person says, because uneducated as he is, he has natural brains. He has the brains of doing things that he is shown by his people who are “sleeping in quietness” those who want him to work by treating people. We cannot dispute what he says.

"sleeping in quietness"
Is a common saying among the Xhosa speaking people when making reference to ancestors.

**R**
Is this collaboration necessary?

**P**
I see it very important that these two groups
should work together because it's not everybody who is sick, is sick because of a disease. It may not be appropriate to treat a patient the western way, even the doctor fails to arrive at a diagnosis, just because the patient is supposed to be treated the African way. That is why I am saying I really long for this collaboration. I see it as extremely important. So?

It's that we have to work together. They need to be work-shopped as I made an example of traditional medicines that has been dug in the forest from the root and make a traditional medicine. Do you realise that the soil has tetanus? I am going to advise that the medicines be washed, then grated and bottled. I wish for that type of collaboration. We also work together as traditional healers.

You know if you can elaborate on this collaboration.

I wish that we traditional healers be recognised. We must not be ridiculed as if, if you are “thwasaing” or using Xhosa medicines you have demons or you are using dirty things. People must know that these are traditional medicines, I'm excluding those that go to “thwala”. Thwasa and thwala are two different things. There has to be a difference. Some herbalists use dirty herbs meant to kill. When you are a traditional healer you should not use dirty herbs, you use herbs that are meant to help people to live and not to die. When performing divination for somebody, I don’t say so and so is responsible for this, I just help her/him as I don't want to cause sour relations with her neighbours. If as a traditional healer you know that so and so is responsible for causing this illness, you have to keep it to yourself, don’t tell him/her because we live on this earth. We have to love one another as neighbours. We must not be the cause of quarrel among people as traditional healers. Is there a thwasa practice and a thwala practice?

"Thwasaing" is something that belongs to your family. It is natural, you are given by your ancestors. To “thwala”…one may, whilst being a
traditional healer, be not satisfied with that and look at another healer who has many clients, then decides to go and acquire a snake which will bring him more money. Those are two different things, traditional healing has purity. “Thwasaing” has no connection with snakes. I think this snake business has to do with greed. That is why I am saying I so wish we can be genuine and not be greedy for money. These are the things that we have to tell one another as traditional healers. If somebody is gifted her/his house is going to be full with clients not necessary for you to “thwala”. That is why I am praying to God of my ancestors not to let me stop working. I want to earn a salary so that I do not charge people a lot of money.

<table>
<thead>
<tr>
<th>R</th>
<th>I am listening with interest in the “thwala” and “thwasa” issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>p</td>
<td>Oh no, Mama, these are just the things that tend to put our traditional healing profession in disgrace</td>
</tr>
<tr>
<td>R</td>
<td>OK then let us continue on the issue of collaboration</td>
</tr>
</tbody>
</table>
| p | I want to say personally, we ought to do it the way things are done in hospital. In hospital you see a patient as a physician, you refer that patient to the specialist and the specialist sees that no, this is not a medical condition but a surgical condition and refers the patient accordingly. I think we should do a similar thing as traditional healers. Nobody can have expertise in everything. I will be an expert in divination, but if I feel I won’t be able to treat that person, I should refer him to another traditional doctor who will do his part. Maybe he will see that this person before he takes the medicines, he must go for “selection/removal of the skin incisions.” Collaboration should be on those lines. One must not think that one is able to do everything. The reason for that is being greedy for money. You want to be the only one benefiting even if you realise that this is not in your line, you should be referring the patient to so and so. That is why I am saying if only we could call one another, talk as traditional healers, but the thing is the heart. I can have this heart but another traditional healer will not see in the same way, all what he wants is to fill his bag with money and
<p>| Removal of skin incisions is a procedure done by a traditional healer to remove the skin incisions on a patient that are said to have been inflicted through witchcraft |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>So you see this collaboration as something that should apply among you as traditional healers?</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>This collaboration should be between traditional healers and western trained, because the western trained healer can realize that this condition is beyond me. This patient has been taking the tablets but is not becoming better. Now I will come out and say, no I am seeing this patient in this light; this person is not sick. Like an adolescent who bleeds excessively during menstruation without stopping. The western trained will continue to give Ovral 28 with no success meanwhile the reason is just she is “naked” she needs a ritual called “imbeleko”</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>OK let’s continue. I hear what you are saying about the traditional healers. I don’t get exactly what you are saying about the western trained healers</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>By the way the meetings that I was suggesting are not solely for traditional healers but will also be attended by nurses and doctors. They discuss the issue of collaboration. Questions and advices will be dealt with there</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Ja, they discuss collaboration. Continue.</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>No, now I feel I have said all what I wanted to say</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>If that is the case, I must thank you for your time and contribution but I may contact you for clarity when I transcribe this interview if I am not clear about something</td>
</tr>
</tbody>
</table>
ANNEXURE H

MAP 1: EASTERN CAPE HEALTH DISTRICTS AND SUB-DISTRICTS/LOCAL SERVICE AREAS

MAP II: AMATHOLE DISTRICT MUNICIPALITY