THE ATTITUDE OF COMMUNITY HEALTH NURSES TOWARDS INTEGRATION OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE IN NORTH WEST PROVINCE.

BY

MMAPHEKO DORICCAH PEU

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by

MMAPHEKO DORICCAH PEU

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SUPERVISOR: PROF R TROSKIE

JOINT-SUPERVISOR: MRS S P HATTINGH

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DECLARATION

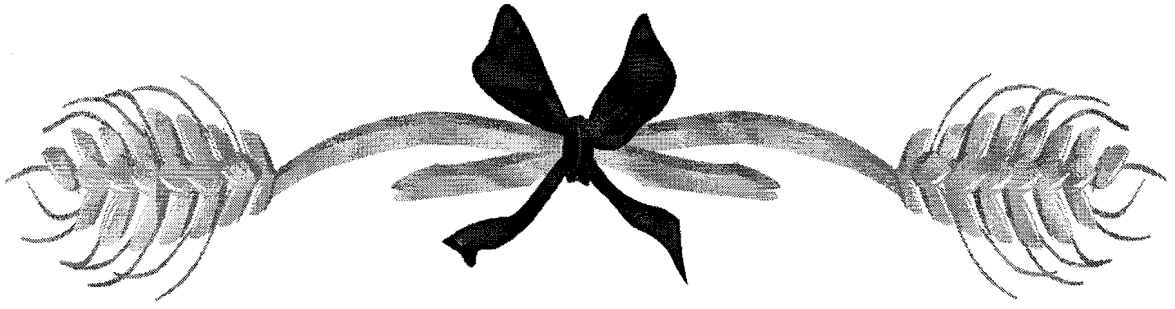
I declare that "The attitude of community health nurses towards integration of traditional healers in primary health care in the North West Province" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

.....
MMAPHEKO DORICCAH PEU

This ..... date of .....JUNE.....2000

DEDICATION

This work is dedicated to: My father, Nkwate Kgosi Reuben Pilane, my mother Mpolokeng Milia Pilane, my husband, Tsie Ephraim , my daughters, Salome, Ephenia and Lesedi, my son, Agang and to the community and the community health care providers in the North West Province especially Odi region (Odi, Brits and Moretele) who are always willing to work as partners in health care provision.



SUMMARY

THE ATTITUDE OF COMMUNITY HEALTH NURSES TOWARDS THE INTEGRATION OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE IN NORTH WEST PROVINCE.

South Africa is called "the rainbow nation" because it has so many different cultures. These have an impact on the provision of primary health care. The purpose of this research is to foster good relationships between community health nurses and traditional healers and to explore, identify and describe the attitude of community health nurses towards the integration of traditional healers into primary health care.

A non-experimental, explorative and descriptive research strategy was designed to explore the working relationship between community health nurses and traditional healers. Data was collected using a structured questionnaire. Quantitative as well as qualitative data analysis techniques were adopted to interpret the findings.

The results indicated that respondents demonstrated positive attitudes towards working with traditional healers, especially in the provision of primary health care. Positive opinions, ideas and views were provided about the integration of traditional healers into primary health care. Respect, recognition and sensitivity were emphasized by respondents.

KEY CONCEPTS

Attitudes, opinions, views, ideas, community health nurses, primary health care, traditional healers, integration of services, roles of traditional healers, constraints, health promotion, illness prevention, transcultural approach.

ABBREVIATIONS

AIDS	:	Acquired Immune Defiency Syndrome
ANC	:	African national Congress
ESCOM	:	Electrical Supply Commission
HIV	:	Human Immuno Deficiency Virus
STDS	:	Sexually Transmitted Diseases
TB	:	Tuberculosis
WHO	:	World Health Organisation
PRHETIH	:	Primary Health Training for Indigenous Healers
UNICEF	:	United Nations International Children's Emergency Fund

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

South Africa is called "the rainbow nation" because it has so many different cultures. These diverse cultures make special demands on primary health care services because nursing aims to provide nursing care to all the people of South Africa – whatever their creed, cultural traditions or ethnic origin. One of the most recent initiatives in South African health care is a plan to coordinate the work of community health nurses and traditional healers in order to meet the health needs of everyone in the country by the year 2000. The National Health Plan states that primary health care should be accessible and available to every member of the community in such a way as to promote health and prevent illness. If such a comprehensive curative and preventative primary health care programme is to succeed, traditional healers will have to be integrated into the national primary health care programme because – as this study will attempt to show – they too have a vital and indispensable role to play in the provision of health care. Suitable mechanisms for integrating traditional healers into the National Health system need to be identified and implemented (ANC 1994:72).

It is vital for community health nurses to accommodate traditional healers and traditional medicine in South Africa with the kind of accommodation that has already been proved to be effective in other countries. "Traditional healers and traditional birth attendants should not, at this stage, form part of the public health service, but should be recognised as an important component of the broader primary health care team. Their skills, experience and expertise should be used optimally to ensure maximum

coverage and cost effectiveness" (White Paper 1997:55-57). If traditional healers are not incorporated into the health care systems of this country, it is the community itself which will suffer. Traditional healers can only be effectively accommodated in the very place where community health nurses meet their own clients, i.e. in the clinic itself.

Traditional healers are native (indigenous) medicine men and women who utilise basic traditional medicines and spiritual principles and techniques to effect cures. Such healers are – and always have been – a part of the community. They are well known in their respective communities where they are accepted, respected and trusted by the communities which they serve (Salus 1994:7). Traditional healing practices should not be undermined by those who (for whatever reason) have an unfavourable attitude to traditional healing. Traditional African medicine has an ancient pedigree that dates from time immemorial and was well established on this continent millennia before Africans had any contact with European civilisation. Traditional healers are able to effect remarkable cures and provide effective treatments for a whole range of maladies and conditions, ranging from physical illnesses to psychological and spiritual. Because traditional healing is one of the most important elements of the cultural heritage of Africa, traditional healers should be included in the provision of primary health care programmes because they can be effective in preventing and curing certain diseases and because most Africans who have not become divorced from their cultural heritage have a deep respect for traditional healers. Commentators such as Swift and Strang (1993:690) agree that arrangements should be made to accommodate traditional healers in primary health care.

Abdool-Karim, Ziqubu-Page and Arendse (1994:10) refer to Dennis and Harrison's (1974:51) study of Liberian health care and noted that herbalist and other traditional healers expressed a great willingness to cooperate

with biomedical practitioners and were even willing to make certain concessions for the sake of cooperation. These concessions included their willingness to be trained in Western biomedical techniques. Traditional healers need to undergo an effective and relevant education programme if they are to become successful participants in modern health care programmes and community health nurses need to have an attitude to traditional healers that will encourage and facilitate partnership and mutual respect in the provision of health care services. The success of a traditional healer's participation in cooperative health care provision will also naturally depend on the attitude of each individual traditional healer towards integration.

Although South African traditional healers currently have no legal status as medical professionals, their legal status as practitioners is currently under scrutiny and will soon be defined. If traditional healers wish to become legally, professionally and socially empowered, their traditional healing practices will need to be regulated and controlled by statutory legislation and by their own professional body. Before that can be done (i.e. before they can be registered as a profession), traditional healers will have to develop (in conjunction with other health professionals) criteria for their standards of practice and a code of ethical conduct. According to Salus (1994:7), traditional healers should work well with practitioners of Western medicine because their training has made them both practical and resourceful. Their natural resourcefulness combined with their professional skills will enable them to complement the health team at this time in South Africa when existing health services are not able to meet the needs of the people. An additional advantage is that the practice of traditional healers has deep roots in local African beliefs, customs and traditions.

Abdool-Karim et al (1994:11) with reference to Ojanuga (1981:52) and Imperator (1979:45) states that research into the attitudes of biomedical staff towards traditional healers in the health care environment shows that health care professionals are willing to cooperate and work with traditional healers to improve the quality of the service that is generally offered. The way forward is for Western health care professionals and traditional healers to jointly identify the kind of basic health care education that will be needed for such practice. Abdool-Karim's (1993:423-424) research on traditional healers and AIDS prevention concluded with the recommendation that traditional healers be incorporated into AIDS prevention programmes so as to reduce the spread of HIV and HIV-related infections. Because cultural practices can play a vital part in preventing the spread of HIV/AIDS, the skills and expertise of traditional healers should be recognised as an indispensable part of the campaign to minimise the spread of HIV/AIDS. Similar research done by Chipfakacha (1994:360-862) into the role of culture in primary health care concluded with the recommendation that traditional healers be incorporated into the modern health care system so that they can help with the identification of diseases such as tuberculosis (for example) before it reaches its advanced stage in individual patients. Often valuable time is wasted before dangerous and fatal diseases are diagnosed. Chipfakacha also believes that traditional healers should be encouraged to refer patients whom they feel they cannot personally care for or treat.

1.2 OUTLINE OF THE PROBLEM AND THEORETICAL GROUNDING

Health and illness may, from one point of view, be interpreted and explained in terms of a personal experience and expectations. Although the term *illness* refers to the experience of a sick person, all illnesses are determined by how a particular society defines such illnesses. An illness is only an illness in a particular society once it has been defined as such by

a health practitioner, a physician and by the community itself (Spector 1991:15, 49). According to Bouer, Dreyer, Herselman, Lock and Zeelie (1997:34), African people who view illness from an indigenous point of view believe that illness can be intentionally caused by a malevolent agency which has control over supernatural (mystical) forces. Black South Africans traditionally believe that practitioners of witchcraft and sorcery can cause certain kinds of illness.

Shai-Mahoko (1997:101) suggests that witchcraft and sorcery would (for all practical purposes) exist for all members of a given group of people if all the people in that group believed in witchcraft and sorcery and all that it entailed in that cultural and ethnic group. Since all or most black South Africans believe in the efficacy of witchcraft and sorcery, it exists for them because it forms part of their world-view. It should be noted at this stage that the terms *witch* and *witchcraft* in African usage have no neutral or positive connotations in African languages, as they do in a Western language such as English where *witchcraft* may denote activities that range from the benevolent ("the white witch") to the malevolent. Throughout this text therefore the terms *witch*, *witchcraft* and *sorcery* will denote the African (i.e. malevolent) understanding of the words concerned. According to *The World Book Dictionary* (1994: 1996), s*orcery* refers to magic performed with the supposed aid of evil spirits.

The reasons why people in a community consult health care providers depend on their choices, their personal experience and their cultural background. Africans from communities in the North West Province consult traditional healers because they know from experience that their interpretation of health and illness is often different from the interpretation that would be placed upon their experience by a Western practitioner. Such people also expect and rely on different remedies to heal their

illnesses. People in communities like this one consult traditional healers because of:

- shortage of equipment in health care centres.
- the attitude of community health nurses
- a lack of transport.
- inadequate information about what health care services are available.

In South Africa at the moment there is an urgent need for health care services to be made as accessible as possible to everyone. If cooperation amongst traditional healers and community health nurses is encouraged, a more comprehensive health care service can be provided to all South Africans.

Research by van Eeden (1993:441) into the future possible role of traditional healers found that there is opposition to the incorporation of traditional healers into the present health care system. van Eeden is of the opinion that if traditional healers are to be integrated into the country's health care system – especially in the field of primary health care – the following steps first need to be taken:

- Their medicines should be identified and tested scientifically so as to verify that they are safe for human consumption.
- Traditional healers should be informed and educated about Western models of medicine and health care before they are incorporated as partners in an integrated health care system.

Health care professionals – especially those who provide health care to impoverished urban and rural communities – should all be trained in transcultural nursing so that they will be qualified to provide culturally

congruent care or be able to refer patients to those who will be able to give it to them. Herbst cites Leininger (1981: 366) that "transcultural nursing refers to a formal area of study and practice that focuses on a comparative analysis of cultures and subcultures with respect to diverse health-illness caring beliefs, values and practices with the goal of generating a scientific and humanistic culture-specific or culture universal therapeutic nursing care practice" (Herbst 1990:36). This means that nurses should understand the attitudes of different ethnic groups to illness and health and how members of such groups react to the causation of illness, to treatment and to care. According to George (1995:377) culture-congruent (nursing) care refers to those "cognitively based assertive, supportive, facilitative, or enabling acts or decisions that are tailor made to fit with individual, group, or institutional cultural values, beliefs and lifeways in order to provide or support meaningful, beneficial and satisfying health care, or well being services".

When a community nurse offers health care to patients from diverse cultural backgrounds, it is important for her to be sensitive to the differences which she encounters among her patients. If the community health nurse is to provide a truly comprehensive service to patients from diverse cultural backgrounds, she needs to possess a sympathetic understanding of those cultural differences which constitute the fabric of the everyday life of her clients. A community health nurse who provides culture-sensitive health care is not only accommodating and respectful of her clients' differences; she also scrupulously avoids imposing her own culture or world-view on her clients. It is vital for community health nurses to be well-informed about specific features of different cultures so that they can assist and support members of particular communities who present with non-Western diagnoses that they have derived from their own cultural contexts. Thus, for example, it would be quite normal for a black patient to

claim that he or she had been bewitched, and that this bewitchment was the cause of his or her illness. A good community nurse accepts the patient's diagnosis at face value and respects his or her analysis. A white community nurse should therefore be as respectful of a black patient's diagnosis of "bewitchment" as a black community nurse might be. There is no place in community nursing for the imposition of one culture on another. Each culture should be accorded the respect and dignity which it deserves. Black culture is not more important than white culture, and white Western culture is not more important than black culture. Where one culture dominates another, health care services will be under-utilised and patients will not receive the care which is their right. Western health care is not superior to traditional African healing practices. Both traditions have a part to play in the new South Africa, and only by drawing on what is best in both traditions will health care professionals be able to offer the service that the country expects of them. Health care professionals should all therefore strive to be accommodating and respectful to clients of all races, cultures and traditions. Conversely, arrogant and uncompromising behaviours should have no place in the health care services.

What is evident in South Africa today is that patients are been torn by competition and mistrust between community health nurses and traditional healers. What emerges from this competition is that there are serious differences between the health care models of community nurses and traditional healers. While traditional healers believe that their patients can be healed only if they abstain from using biomedical medicines, community health nurses do not believe in the efficacy of traditional healing medicines. They therefore, discourage their patients from using traditional medicines and, in so doing, they implicitly criticise the craft of African traditional medicine.

Regardless of the success rate of traditional healers, traditional healing practices are essential to health care provision among the communities of North West Province. The research of Peu (1997:17) shows that community health nurses are willing to work with traditional healers if traditional healers have been educated about what Western-style healers are trying to achieve. It is vital for traditional healers to be empowered with basic health care knowledge and information because they serve as the first point of contact between people who are ill and any kind of health care system. It is vital for community nurses and traditional healers to be in agreement about how to treat the most commonly encountered health problems such as, for example, patients who present with diarrhoea and vomiting. Community nurses and traditional healers should also be in agreement about when to refer patients who cannot be treated in local clinics. Nurses and traditional healers should respect one another and work as a team. The study is grounded on the following concepts that emanated from this discussion:

- African's view of illness and why traditional healers are consulted
- Incorporation of traditional healers in the health system
- Humanistic cultural specific care.

1.3 BACKGROUND OF THE PROBLEM

According to Searle (1987:7), primitive people believed that all diseases were caused by supernatural agencies. It was among such people that the art of traditional healing developed over millennia until it became the highly sophisticated and complex system that we know today. In cultures all over the world, shamans, medicine people, witchdoctors and traditional healers have traditionally been accorded the greatest esteem and honour because of the vital services which they render in the community. The services of such people have been indispensable to the well-being of the

human race since time immemorial. It was only with the advent of colonialism that the Western model of medicine became influential all over the Third World. As the self-understanding of indigenous people became distorted through the imposition of the Western modes of understanding, the prestige which people traditionally accorded to traditional healers was subverted. The kind of Christianity which accompanied the colonisation of the Third World diminished the value of all traditional African practices, including traditional healing. Traditional healing was regarded by the missionaries of the nineteenth century as a manifestation of heathen culture that a convert to Christianity should renounce. The devaluation of traditional African culture by missionaries and colonisers created a kind of cultural schizophrenia in the hearts and minds of African converts to Christianity. While many Africans found much of value in the new religion, most found it impossible to forget the ways of their ancestors. While many therefore were outwardly, and quite genuinely, Christian in their beliefs and practices, most continued to observe the traditional ways by, for example, consulting traditional healers when they felt that Western-style medicine was not able to help them. A tremendous amount of research has been done to establish the value of traditional healing practices, and in many cases traditional African remedies and healing techniques have been vindicated by this kind of research. It is now also accepted in Western medicine that faith in the healer is an essential part of the curative process.

The research of Abdool-Karim et al (1994:4) confirms that African traditional healing is based on beliefs and practices which existed long before the development and spread of modern scientific medicine. Most African people have not lost their primal belief that certain kinds of illnesses can be caused by witches. A person who is jealous of another may pay a witch to cast a "spell" on that person so that he or she becomes ill. The validity of this practice is still widely accepted among Africans. A

person that has been thus may present at a clinic with a condition that can only be treated by a traditional healer. In such circumstances it is important for the community nurse to accept the patient's diagnosis and refer him or her to a traditional healer. If a genuine sympathy exists between community nurses and traditional healers, they will find it easy to cooperate in the best interests of their patients. It is only when a community nurse exhibits hostility to the diagnosis which the patient offers that confusion will arise for all concerned. In such circumstances the patient will inevitably end up consulting a traditional healer anyway. Where community nurses are sensitive to cultural differences, it is the patient who benefits.

If a family believe that one of them is bewitched: a traditional healer is consulted because he or she is naturally regarded as the person most likely to be able to counteract the effects of the witchcraft (Bouer et al 1997:35). African traditional healers have a reputation for being resourceful, readily available and accessible. Such a person combines in himself or herself the knowledge and ability to consult the patient, to examine, to diagnose – and to treat the patient according to traditional healing practices.

Africans consult both traditional healers and Western-style medical practitioners because they understand that both kinds of healers share the common goal of providing services and treatment that have the health and well-being of the patient as their goal. Human care is a universal value across cultures and caring can be demonstrated through diverse expressions, actions, patterns, life style and meaning (George 1995:375). Africans demonstrate their caring in the same way as people in other cultures do. According to Peu (1997:12), community health nurses in the Moretele district in North West Province are sometimes confronted with complications arising out of advanced cases of tuberculosis and chronic

diarrhoea, which have been referred to them by traditional healers. While there is no doubt that traditional healers treat their patients as well as possible under the circumstances in which they find them, fatalities sometimes occur because of delays in the consultation and treatment of conditions such as diarrhoea. It is a cause for deep concern that such delays may be the consequence of poor relations between traditional healers and community health nurses as well as the confusion created in the minds of patients by old-fashioned tensions between the world of the community nurse and world of the traditional healer. The people who suffer most when hostility exists between Western-trained healers and traditional healers are the patients themselves. In the country such as ours where resources are stretched to the uttermost, there is no room for hostility between traditional healers and community health nurses in the management of disease. What is needed in South Africa, both in urban and in rural areas, is that community health nurses and traditional healers should resolve their differences and appreciate the role that all kinds of healers have to play in the provision of health care. It is only in an atmosphere of called cordiality that the historical antagonism between Western-style medicine and traditional medicine can be obliterated once and for all.

Because the ideal situation is one in which Western-style medicine and traditional healing practice complement each other, community health nurses and traditional healers need to create a partnership among themselves that will enable them to provide health care for the whole nation. Because of the lack of funds, the enormous backlogs created by apartheid and the challenging logistical problems created by a lack of proper infrastructure in some parts of Southern Africa, the provision of primary health care for all the people of this country – but especially for the poorest of poor, most of whom live in inaccessible rural areas – is one of the greatest challenges of South Africa's second democratic

government. The government is quite clear about what *it* hopes that the country's health services will achieve. The White Paper envisages nothing less than primary health care for all the people of South Africa, no matter where they live or in what condition they find themselves (White paper 1997:55)

Because traditional healing is an integral part of South African cultures and communities have believed so since time immemorial, and because it fulfils functions which go far beyond those which biomedical health care workers (doctors and nurses) see as appropriate to their professions (Abdool-Karim et al 1994:2), traditional healers exert an enormous influence on their patients, their families and the community. In general traditional healers make a very positive and beneficial contribution to the cultural and spiritual life of individuals and communities. What has been neglected thus far is the fact that individuals and families have the right to make their own choices and decisions about the kind of health care which they wish to receive. Where the right of patients to make their own choices about health care is respected, it is inevitable that the spiritual, physical and mental well-being of communities will be maximised.

Africans will continue to consult traditional healers (as they have done for millennia) because they have been socialised from earliest childhood to do so. All Africans, no matter how modern in outlook they have become, share the same norms and traditions. While some Africans no longer abide by the ways of the ancestors, there is a renewed interest, even among urbanised blacks, in the old ways. Many Africans are re-examining ancestral traditions and customs in the hope of finding a new identity that is both African and modern.

People should be encouraged to consult traditional practitioners because it is a part of their cultural heritage and belief system. And traditional

healers should be given every opportunity to utilise their skills in the community because South Africans, especially those who are poor and have no or little access to medical services, need all the help they can get.

Kelly (1995(a):686) conducted research into the possibility of cooperation between traditional healers and medical personnel. One of Kelly's conclusions is that meaningful cooperation between traditional healers and biomedical practitioners (community health nurses, for example) is impossible. The reason advanced for this, in the opinion of the researcher, is that fundamental differences about what causes disease prevents any kind of practical cooperation between those who practise traditional medicine and those who have been trained in Western medicine. In spite of the conclusions reached by Kelly, or even because of them, it is vital not to underestimate or devalue the theory and practice of traditional African medicine. Even if the premises of traditional African medicine and Western medicine are incompatible and irreconcilable (and this is not a question upon which any final conclusion can as yet be pronounced), it is still important to allow those seeking medical help to consult whomever they wish – whether African traditional practitioners or Western doctors. It is especially important to encourage patients to make their own choices in view of the fact that traditional medicine was denigrated for centuries by Westerners – and especially by missionaries, who regarded traditional African medicine as something demonic and evil.

One of the features that makes traditional healing so acceptable to African people is the fact that the healer is always available and accessible. Koloko (1997:17) states that one of the main reasons why traditional healers remain so popular and trusted (apart from their affordability and accessibility) is that they focus on the well–being of the patient, and not simply on the treatment of his or her condition. He further says that what

makes the traditional healers acceptable to the community is that they are always friendly and welcoming, and that they encounter the client in the totality of his or her situation. To the traditional healer, the client is not just a "medical" problem.

Traditional healers are, and always have been, an indispensable part of the national health care equation. If the quality of health care provision to the South African population is to be improved, programmes need to be devised and implemented that will facilitate cooperation and collaboration between traditional healers and community health nurses. Successful collaboration and integration of the kind envisaged in this research will take some of the pressure off the formal (Western) medical sector, thus allowing them to improve their services in those areas in which they obtain the best results. Successful collaboration and its accompanying increase in status will also belatedly confer on traditional healers the prestige and status which is rightfully theirs but which they have been denied since the beginning of the colonisation process in Africa.

1.4 SIGNIFICANCE OF THE PROBLEM

Various efforts are currently being made to implement primary health in South Africa as a whole. As things stand at the moment, available resources are simply not able to provide the quality of health care that the government envisages for all the people of South Africa. For historical reasons, about 80% of the white population are supported by generous medical aid schemes that enable them to be consumers of quality health care. About the same percentage of the South African black population are not supported by medical aid schemes and furthermore, in most cases, simply do not have the financial resources to consult doctors or health professionals who are trained in the Western model. Mahape (1995:12) notes that most South Africans simply cannot afford Western-

style medical care and view the formal medical establishment (such as community health nurses and the services offered in clinics) as unfriendly, remote and therefore irrelevant to their plight. These same people, however, will, in an emergency, consult traditional healers for a variety of ailments which range from psychological distress and fears about bewitchment to the common physical ailments which Western-style doctors and community nurses encounter. The irony of this situation is that traditional healers are not recognised by the health authorities and that most medical aid schemes will not subsidise patients who consult them. In spite of these disadvantages, they continue to render valuable and indispensable service to their patients. People continue to consult them, not just because they are part of African culture tradition and not just because they are popular, well-respected and highly regarded in the community – but because they deliver *results* (i.e. they have a very high success rate and give satisfaction to their clients) (Loveday 1999: E-Mail).

This research is important because it sets out to investigate the attitude of community health nurses towards the integration of traditional healers in primary health care. This research could lead to an improvement in the quality of life of individuals and a renewed respect for human and cultural rights. South Africa has a long and unfortunate history of disregard for human rights and cultural diversity. The identification and resolution of the problems experienced by community health nurses and traditional healers (such as, for example, poor communication) will have the effect of improving the provision of health care for the whole population. This can only happen if health care methods are recognised and accommodated on an official level and if traditional healers and community health nurses are officially regarded as being of equal importance in status – in spite of diversity and differences in methods, techniques, treatments and world view. This research aims to create and nurture a trusting relationship among healers and community health nurses. Such trust, once created,

will lead to an improvement in the quality of health care services for all the people of South Africa – and not just the privileged few. Conflict will be eliminated and new forms of trust and respect will arise as people who were previously hostile to each other find that they have every reason to respect and support each other.

1.5 AIMS OF THE STUDY

The purpose of this study is to investigate ways and means to foster a good working relationship between community health nurses and traditional healers.

The specific objectives of this study are to:

- identify the attitudes of community health nurses towards integrating traditional healers into primary health care
- identify and describe the role which traditional healers play in the community
- identify the factors which constrain traditional healers from being integrated into primary health care
- determine ways of facilitating the integration of traditional healers into primary health care

The researcher devised the following research questions as the basis for her research plan:

- What is the attitude of community health nurses towards the integration of traditional healers into primary health care?

- What roles do traditional healers play in the community?

- What factors hinder the integration of traditional healers into primary health care?

- How can traditional healers be assisted to integrate into primary health care?

1.6 DEFINITION OF CONCEPTS

For the purpose of this study, the following definitions will apply:

1.6.1 **"Attitude"**

Attitude is a way of thinking and acting; it is the behaviour of a person towards a situation (*The World Book Dictionary* 1994:132). According to Fisher (1984:56), attitudes are more or less a permanent state of readiness, of mental organisation. They predispose an individual to react in a characteristic way to any object or situation, thus constituting a predictor for expected behaviour. Attitudes are highly emotive feelings which reflect a person's state of mind towards various values.

1.6.2 **"Community health nurse"**

According to Dr Chang of the World Health Organisation, a community health nurse is a generalist who is capable of functioning in a health team. He/she is capable of communicating with and motivating people. He/she is also capable of working effectively with educational, social and other

workers in the community. Such a term may be applied to many categories of nurses (De Haan 1996:8). In this study *community health nurse* refers to all categories of nurses (psychiatric, registered nurses, registered midwives and enrolled nurses) working in the community.

1.6.3 **"Primary health care"**

According to the National Health Plan of South Africa, primary health care is based on practical, scientifically sound and social, acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at the 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 (ANC 1994:20).

A similar definition is given by WHO/UNICEF's joint report:

Primary health care is an essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at the cost that the community and the country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall, social and economic development, of the community (Searle, Brink & Grobbelaar 1991:141).

Primary health care is the first level of contact with clients and it is the kind of care that most people are likely to encounter at grassroots level. It should meet the needs of those who rely on it because they cannot afford any other kind of medical care.

1.6.4 "Traditional healer"

According to the Oxford Dictionary (Hawkins 1986:237, 871), a traditional healer is a practitioner who bases his/her healing practice on an ancient system of culture, custom and beliefs that had been passed down from generation to generation from time immemorial. While Abdool-Karim et al (1994:7) identify four types of traditional healer, namely inyanga, isangoma, umthandazi and traditional birth attendants, Troskie (1997(a):17) identified seven different types of healers, namely the sangoma, the prophet, the inyanga, the herbalist, the birth attendant, the sangoma birth attendant, and the sangoma prophet. Each type of traditional healer manifests and utilises his/her own skills, techniques, services and methods of making his/her services accessible to his/her clients. Each different kind of healer uses different methods to diagnose what is wrong with his/her patients, although some methods of diagnosis have been handed down from one generation to another of healers because they have been found to be especially efficacious. Each individual healer stamps standard diagnostic techniques with his or her own unique individuality.

1.7 ORGANISATION OF THE STUDY

The orientation of the study is discussed in chapter one where the problem is clearly stated and analysed based on the theoretical grounding. The background to the problem is also discussed and analysed, the aims and objectives of the study are clearly stated and the significance of the problem is discussed. The important concepts and research questions which are structured in terms of stated objectives, are given.

Chapter two reviews the literature and describes the sources. In chapter two the books, articles and other sources such as people who were

interviewed and information obtained from radio, television and newspapers are identified.

In chapter three, the methodology is analysed and discussed.

The analysis of data, as well as the discussion and interpretation of research findings, are presented in chapter four.

In chapter five the final comments and limitations of the research are given. Recommendations for future research are suggested.

The list of references lists the sources from which information was consulted. Such sources include books, articles, newspapers, radio, television programmes, symposia and proceedings of various congresses. The appendices contain copies of the letter by means of which permission to conduct the study was requested, the letter which granted permission to conduct the study, and the data collection instrument.

1.8 SUMMARY

There is an urgent need for traditional healers to be integrated into South Africa's system of primary health care provision . Existing services are not always able to meet the needs of the majority of the population because they cannot afford it or else it is inaccessible to them in the places and under the conditions in which they live. It is the researcher's belief that traditional healers will be able to make a crucial contribution to the promotion of good mental and physical health and the limitation and control of pandemics such as HIV/AIDS. Traditional healers, if properly trained, will also be able to refer clients, whom they cannot treat, to hospitals and clinics. All in all, the ancient wisdom and skills of traditional healers are urgently needed in modern South Africa because government-

sponsored health services are already so over-extended that they are unable to offer primary health care even to those who need it.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The literature review will examine what is known about the attitudes of community health nurses towards the integration of traditional healers in primary health care. The role of the traditional healers in the community, the hindrances which hamper an effective integration of traditional healers into official government-sponsored health care systems, and possible ways of facilitating the integration of traditional healers into primary health care provision will be scrutinized. Views, attitudes and opinions of community health nurses, various research findings, and the attitudes of other health care providers will be identified. The main focus will be on attitudes to relations between traditional healers and community health nurses. Information obtained from radio programmes and newspapers was used to obtain a fuller picture about existing collaboration and integration between traditional healers and community health nurses. The literature review was also utilised to structure the questionnaire for data collection.

2.2 THE ATTITUDE OF COMMUNITY HEALTH NURSES TOWARDS THE INTEGRATION OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE

2.2.1 International views about the integration of traditional healers and modern health care systems

There is no realistic hope of extending health provision in many countries today unless pioneering measures such as inviting traditional practitioners

and the medicines which they prescribe are adopted (many of which are compounded from local plants) to become an official part of health care provision systems (Bellakhder 1989:194). Morocco is one of the countries which has recognised and honoured their indigenous traditional healing practices. Bellakhder (1989:193) mentions that traditional medicine is still popular in Morocco because it is an important form of health care for many people. Traditional medicines are known to achieve excellent results in treating a wide range of common ailments such as afflictions of the ears, nose, throat, lungs and bronchi. Bellakhder supports the notion that traditional medicine should be involved in basic health care.

At an international conference, *International Black Nurses Share Health Issues for the 21st Century*, held in Botswana from 26 July to 30 July 1998, several participants, especially those whose papers were concerned with transcultural nursing issues, supported and promoted the ideals of cultural sensitivity in society and in nursing. In a paper delivered at the conference, Selelo-Mogwe (1998:2) noted that paradigms of health promotion and disease prevention continue to operate on assumptions that are derived from the Western medical model and that diagnosis, patient care, treatment and outcomes are all strongly and directly influenced by the Western model. Although, as Selelo-Mogwe notes, Western medical practice confers enormous benefits on patients, it operates as a culturally monopolistic system that places Western cultural assumptions at the centre of practice while more or less ignoring the cultural beliefs of other patients (such as Africans).

As part of the campaign to incorporate traditional healers into the national health care system and recognise the role which they have to play in the prevention of disease and the promotion of health, an international conference was held at the University of South Africa (Unisa) between 18 and 20 August 1998. The theme of the conference was Global

multidisciplinary health care into the 21st century and many participants emphasised the need for health care providers to make cultural sensitivity (sensitivity to cultural differences among patients) one of the most prominent features of health care provision. Participants emphasized the need for cooperation and collaboration with traditional healers and reiterated how important it is for traditional healers to be incorporated into South Africa's traditionally Western health care system. One of the recommendations was that research should be done so that ways of collaborating with traditional healers could be identified and procedures for integrating them into South Africa's Western-style system of health provision could be established. The following questions are relevant to these issues: What are the constraints that prevent effective integration? In what ways can integration be promoted? There is also the need to identify the views or attitudes of modern health care providers towards such integration.

Chipfakacha (1994:860-862) emphasizes that traditional healers are the first and nearest contact for the rural black Africans and are very popular because they provide culturally familiar ways of explaining the causes and prognosis of ill-health. Despite their shortcomings, traditional medicine offers several advantages to the community. Modern doctors are often alienated from their patients by social class, economic position, specialized education and cultural background. These are factors that alienate many patients, both black and white, but especially black patients from rural areas and those who live in conditions of great poverty and hardship on the peripheries of the great cities. To such people, a visit to a traditional healer is the most obvious and logical way to respond to some condition that requires medical or psychological (spiritual) treatment. If traditional healers are skilled at diagnosing those conditions which they cannot treat by traditional means, they will be able to refer their patients to those kinds of clinics or hospitals which provide Western-style medical

care – and where such care might be the most appropriate and effective response to the patient's illness. The incorporation of traditional healers into primary health care services by training them to recognise those conditions which they cannot treat, will ultimately enhance the profession of traditional medicine and benefit patients. If traditional healers have been trained to refer patients with serious complications (such as advanced tuberculosis) to Western-style hospitals and clinics, the patients themselves will benefit and the reputation and prestige of traditional healers will, in the long run, be enhanced, both in the community and at the national level. But for this to happen smoothly, health care providers such as doctors, nurses and health care administrators all need to show that they have a realistic but profound respect and regard for traditional medicine and the contexts in which it is practised. They also need to exhibit a strong desire to see traditional healers incorporated into the primary health care system in a way that will give public recognition to the respect and prestige which traditional healers have enjoyed in African society for millennia.

Traditional healing has always been an essential part of the multicultural social fabric of South Africa, but the time has come for this to be recognised at an official level and in the day-to-day administration of the national health care system by, for example, encouraging medical aid schemes to recognise visits by patients to traditional healers.

The World Health Organisation (WHO) supported the recognition of traditional medicine in its statement in 1976 before the Alma-Ata Declaration and WHO decided to show how serious it is about the recognition of traditional medicine throughout the world by establishing a special programme at its headquarters in Geneva. WHO thus fully supports initiatives to recognise traditional healers as part of the world's heritage of medical care and provision. It has specifically focused on the

importance of traditional medical practice by emphasising the need to accommodate and incorporate traditional healers into the global medical system. During the decade between 1976 and 1986, WHO focused its attention and resources mainly on the five areas mentioned below in its efforts to develop collaboration and to encourage its member states to mobilize their own resources for such collaboration. What WHO in Staugard (1989:96-98) emphasised during this decade were:

- consultations that would promote the development of national policies on traditional health workers.

- appropriate training programmes for various kinds of traditional health workers.

- the need for programmes to evaluate and assess the therapeutic efficacy of traditional remedies and practices so that the success rates of traditional medicine could once and for all be established.

- the development of guidelines for integrating traditional medicine into other comprehensive health care systems.

- research and development in all fields of traditional medicine.

The information obtained from these initiatives constitutes a core of knowledge and expertise about how traditional healers may be integrated into primary health care provision. WHO in Staugard(1989:96-98) actively

supports collaboration among the global network of institutional centres which are charged with specific research and development projects that affect traditional healers as individuals and as members of a profession. It is imperative that all individuals and institutions concerned with the improvement and enhancement of the status, prestige and material welfare of traditional healers, cooperate on an international level to promote and coordinate the various programmes and policy initiatives which are designed to integrate traditional healers into national health care provision. Traditional healers should be respected and given the recognition which is due to them for the vital contribution which they can make to health care provision – especially in Third World countries where the need is great and where resources are few (Staugard 1989:96-98). An essential component of such recognition is that traditional healers be accorded all the benefits that accrue from government subsidy and recognition by medical aid schemes. In South Africa this is already happening but not nearly on a large enough scale. The medical aid scheme of ESCOM which is one of the pioneers in recognising the validity of African traditional medicine, subsidises those of its members who choose to consult traditional healers (Mabry 1997:21).

In other countries such as the Philippines, Sierra Leone and Sri Lanka, where, like South Africa, Western-style medical and nursing resources are stretched to the utmost, the government supports the work of traditional healers, especially traditional birth attendants and professionals who offer curative and preventative services to their clients. In the Philippines, a survey was undertaken to identify problem areas before a training programme for traditional birth attendants was undertaken. The committee which undertook the survey collected and analysed the data which showed that most of the traditional birth attendants lacked information about specific health issues and procedures and that their utility would be increased if they were better informed. Once this had been established, a

training programme for traditional birth attendants, funded by the Ministry of Health, was initiated in 1971. The training was supervised by nurses and the objectives of the training programme were met. The objectives for this training programme for traditional birth attendants were a reduction in mortality rates (maternal and infant) and the more effective promotion of health in mothers and infants. This specific programme suggests that if the unique contribution of traditional healing practitioners is recognized, respected and integrated into primary health care, all concerned stand to benefit (WHO 1981:37-70).

In many countries, collaborative initiatives on a national level are taking place, with, in most cases, the Ministry of Health of the country concerned taking responsibility. Countries such as Ghana, Nigeria and Kenya have introduced traditional medicine into the syllabus of specialist institutes and university departments. In Swaziland, two United States agencies for international development initiated collaborative efforts with concerned local parties and sponsored programmes to control the rural water-borne diseases in 1983. Traditional healers were specifically involved in these programmes to prevent water-borne diseases. They were also taught how to prepare and administer oral rehydration therapy and how to integrate this kind of treatment into their rituals (Abdool-Karim et al 1994:12). (According to the World Book Dictionary (1994:1801), *ritual* is a form or system of rites, e.g. the rites of baptism.)

The project continued until 1988 when it was suspended by the government because of problems which the government encountered in its attempts to recognise the national association of healers. Despite this setback, it seems as though collaboration is continuing at the local level in Swaziland. In 1987 a training programme for traditional healers was implemented and this programme involved both traditional healers and biomedical personnel. The impact of training on healer practices was

found to be favourable. The rate of neonatal tetanus was reduced after a training programme in Swaziland (Abdool-Karim et al 1994:12).

It is vitally important to integrate traditional healers into primary health care because (to mention but one advantage) they are advantageously placed to contribute to the prevention and control of communicable diseases through contact with their clients.

2.2.2 South African views about integration of traditional healers and the Western health care system

Because South Africa comprises a multicultural society in which different people have different views and opinions about traditional healers, health care providers and traditional healers also tend to have different views, opinions and perceptions of each other. It is very important to identify the attitudes of health care providers in this country towards integration of traditional healers in primary health care because traditional healing practice forms a part of African culture and most health care providers who are not black are ignorant to a greater or lesser extent about African culture and practices.

Herselman, in Mathe (1996:44-46), warns that the integration of traditional healing and established medicine will be a long and complex process but notes that a combination of health care systems (traditional and Western-style) are successfully utilised elsewhere in the world and that it is necessary for South Africa to pursue this path. Mathe also asks about the level at which primary health care and social health care should be provided if a combination of two health care systems is established in South Africa. Mokae, in Mathe (1996:44-46), suggests that traditional healers be legally recognised and integrated as part of the mainstream medical fraternity. The successful integration of traditional healers into

primary health care requires collaborative effort among health care providers.

Dheyongera (1994:16) suggests that because traditional medicine is practised in developing countries, it should not be ignored by those involved in strategic planning and the development of health care systems. He is of the opinion that traditional healers should be trained and educated to fill the vacuum in the health care delivery system which is created by a shortage of personnel and the high cost of training Western-style health workers. The integration of traditional healers will promote good relationships among providers of primary health care because both kinds of health care provider will have opportunities to share problems. Integrating traditional healers into primary health care services will be appreciated by most black health care providers because they belong to the same culture as their patients and share common beliefs, values and symbols of communication. Because South Africans suffer from a high incidence of psychosomatic diseases, the acceptance of traditional healers as valid medical practitioners will greatly benefit patients who are suffering from such conditions because traditional healers are known to be effective in the treatment of psychosomatic disorders.

Most South Africans receive their medical care from traditional healers. The medical aid scheme of ESCOM (Electricity Supply Commission), one of South Africa's largest companies, recognises visits by its employees to traditional healers. They are recognised as valid medical consultations, and such visits are subsidised accordingly. An ESCOM spokesperson announced that this scheme is still in an experimental stage but that ESCOM expects its employees to benefit from it (Mabry 1997:21).

The Themba Traditional Healers Scheme is a scheme which registers sangomas as providers of traditional healing services and employs clerical

staff to carry out the administrative tasks (such as billing and the collection of payments) associated with such services. This scheme is therefore responsible for enrolling competent sangomas for its clients and the supervision of administrative tasks such as the making of payments from the scheme's funds to individual traditional healers (Mabry 1997:21).

This is a promising indication that employers are beginning to recognise that the job satisfaction of their clients also depends on the extent to which employers provide support systems that take into account the traditional social and cultural beliefs of their employees. Sensitivity of this kind to cultural variations will, in the long run, increase job satisfaction and the promotion of harmonious conditions in the workplace.

The vision of health for all by the year 2000 calls for a comprehensive approach to health. It has already become apparent that the inclusion of traditional healing in the health care system will make this aspiration a reality. Because traditional and Western healers both work towards a common goal – the health of the patient – it seems only logical that they should be partners rather than opponents. If traditional and Western healers are accorded an equal status in the new health care system, patients seeking health care will have a greater choice about the kind of healer they wish to consult. This is an important consideration in a democratic South Africa (Hopa 1997:18). The most compelling argument for the integration of traditional and Western healers is that they complement each other in the provision of health care. Although some Western healers still have a negative attitude towards traditional healers, programmes should be devised to educate Western practitioners about the value and effectiveness of traditional medicine for treating certain forms of disease – both physical and mental. According to Hopa (1997:18), non-Western healers support an integration of the two health care systems. Strategies to effect integration include the promotion of

cooperation between the two health care systems and the separate registration of practitioners from different medical systems.

Thabede (1991:11-14) emphasises the need for collaboration between Western scientific healing and traditional cultural healing until effective integration is achieved. After comparing the two health care systems, Thabede came to the conclusion that although both systems have idiosyncratic shortcomings, they nevertheless complement each other because each health care system is most effective where the other is most deficient. Practitioners from both health care systems should be prepared to learn from each other because the integration of traditional healers will deliver benefits in those areas where Western medicine is often least effective. Since collaborative efforts have already succeeded in Africa and in other parts of the world, traditional and Western-style healers should be prepared to admit that they have a lot to learn from each other. Practitioners from both sides should now begin to make a serious study of what the other side has to offer.

Swift and Strang (1993:690-691) and Karim (1993:423-425) support the incorporation of traditional healers for AIDS prevention and emphasise that traditional healers have a vital role to play in HIV/AIDS prevention. While it is the responsibility of the government to lead the fight against HIV/AIDS in South Africa, the government alone cannot succeed in the battle to contain this pandemic. Unless every citizen in every community does whatever he or she can to prevent the spread of HIV/AIDS, all good intentions, all campaigns and all policy statements will come to naught. Traditional healers are in the front line of those who encounter people who are already infected with the HI virus as well as those who fall into one of the high-risk categories of those who may be infected.

The integration and inclusion of traditional healers in the health care system of South Africa is essential because South Africa is demographically multicultural. Such integration is in fact supported by many health care providers. In the research done by Bodibe (1988:87) into the "inclusion of traditional healers in mental health", the researcher found that both traditional healers and the majority of mental health team members agreed to cooperate with each other in the treatment of psychiatric patients. The traditional healers involved 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 in terms of which they (the traditional healers) would do the same.

Mahape's (1995:74) research into "the attitude of professional psychiatric nurses towards working alongside traditional healers as providers of mental health" indicated that current attitudes have changed towards a more favourable acceptance of traditional healers. The community in fact showed an attitude of open-mindedness and readiness to accommodate traditional healers. The attitudes of some of the nurses involved in the study showed that they wished to acknowledge the personal worth and uniqueness of each patient and honour the choices which he or she wished to make about treatment. Attitudes among those surveyed ranged from a strong advocacy of traditional healers among those who encouraged patients to utilize the services of traditional healers to conditional acceptance and, at the other end of the scale, a total unwillingness to cooperate with traditional healers and a rejection of what they have to offer. The nurses favoured the option of cooperation and collaboration which is based on a belief that Western-style and traditional medicine should be regarded as "separate" but equal and that practitioners on each side should respect the knowledge, skill and endeavours of those on the other side.

2.3 THE ROLE OF TRADITIONAL HEALERS IN THE COMMUNITY

While Blackett (1989:4) classified traditional healers as inyanga, isangoma and umthandazi, Troskie (1997(a):172), as mentioned earlier, provided a more detailed taxonomy of traditional healers and their roles. Mahape (1995:4) cites Bannermann, Burton and Chen-Wen-Chieh (1983), who defined the traditional healer as a person who is recognised by the community in which he/she lives as competent to provide health care by using treatments derived from vegetable, animal and mineral substances, and as a person whose curative practices are based on traditional forms of social, cultural and religious knowledge, attitudes and beliefs that have been passed down in the community since time immemorial. These traditional forms of knowledge and skill enable the traditional healer to treat patients who are suffering from physical, mental and social dysfunction, disease and disability.

Traditional healers play a major role in community life. Their main role of course is to provide health care for their patients. There are various kinds of traditional healers and differences in diagnostic practice and treatment arise out of differences in training.

Traditional healers treat specific illnesses and provide social and spiritual services. Their comprehensive service may include curative, preventive and rehabilitative services for the patient. This was confirmed by Zungu (1992:24) in his research on traditional healers in the work situation. Zungu points out that traditional healers were the only medical practitioners in Africa before the arrival of white settlers and that the indispensable services which they rendered to the community before the advent of colonisation continues even today. It is because traditional healers are so successful in providing truly comprehensive treatment for

their clients that they are respected, revered and admired by the community.

In South Africa many traditional healers are already involved in HIV/AIDS prevention through counselling and through their integration into the primary health care system. Swift and Strang (1993:690-691) are of the opinion that all available resources in the country need to be mobilised as part of the HIV/AIDS prevention campaign. If traditional healers can be properly utilized in AIDS prevention, infection and mortality rates in South Africa will be reduced.

The integration of traditional healers into primary health care will enhance the roles which they already play in the community and will promote the cause of good relations generally in the community. Blackett-Sliep (1989:43-44) supports the proposition that traditional healers can play a decisive role in community health care because they are resourceful and because they know their clients and the conditions in which they live. They have their own traditional ideas about the importance of diet, exercise and rituals – all of which may have real preventive and therapeutic value. Their availability, holistic approach, familiarity with local conditions, effectiveness and encouragement ensure that they are as widely consulted now as they were in pre-colonial times. According to the White Paper (1997:55), traditional healers should be recognised as an important component of the wider primary health care team.

In two case studies carried out in the Mutari Provincial Hospital in Zimbabwe, Chipfakacha (1994:860-862) focused on the role played by traditional healers in the community. It was found that although traditional healers have various limitations (as do all medical practitioners), they are effective for providing primary health care to the rural people who constitute their clientele. Well-trained traditional healers can identify

diseases that can be prevented or modified. They can also cure certain diseases and are skilled in encouraging community participation.

Training programmes in countries such as China, Swaziland, Ghana and Nigeria have facilitated cooperation between traditional and Western-style medicine and have promoted and enhanced the role of traditional healers in their communities. In Nigeria, for example, the training of these healers has impacted on neonatal mortality by reducing the incidence of neonatal tetanus (Abdool-Karim et al 1994:12). If the gaps between traditional healers and biomedical personnel are bridged, traditional healers will be encouraged to lend their expertise to health programmes.

According to the World Health Organisation (1991:25), traditional healers are used in the community because they :

- are available and willing to work in community health
- perform a wide range or primary health care tasks and community projects
- educate people about health problems and methods of preventing and controlling them
- advise their clients about dietary problems and proper nutrition
- concern themselves with ensuring that their communities have an adequate supply of safe water and basic sanitation
- promote maternal and child health care

- play a crucial role in immunisation programmes by referring children under five years old to clinics for vaccination against various infectious diseases

- promote the prevention and control of local endemic diseases

Traditional healers are indispensable role players in community health programmes because no community health programme can succeed without their cooperation and goodwill. Although such cooperation and goodwill have not been utilised to the best advantage in the past, the creation and implementation of carefully designed, sustainable and sensitive integration programmes will ensure than traditional healers play a proper role in the provision of primary health care in the future.

2.4 PROBLEMS IDENTIFIED AS CONSTRAINTS TOWARDS INTEGRATION

If traditional healers, community health nurses and biomedical personnel are to work successfully as a team, they need to integrate the services which they offer by encouraging collaborative effort among members of the team. The best way for different kinds of medical professionals to cooperate is by clearly demarcating those areas in which they are independently successful and by respecting and recognising the importance and value of the unique expertise, knowledge and skills which the other side has to offer. A mutual referral protocol will have to be agreed upon, and there will have to be agreement about which disorders and diseases need to be referred and to whom they will be referred. Cooperation in patient care is one element of collaboration: it means working together towards common goals. It may or may not involve dividing different types of tasks. Traditional healers will have to conform to

certain standards within the "formal sector" (Mahape 1995:24). A lack of collaboration and integration leads to various problems for the community and health care providers – problems such as the delayed referral of patients and poor communication. Such problems could lead to constraints which will hamper integration. Mahape also notes that indigenous healing is feared by many people who equate it with witchcraft – and therefore as deceitful, malevolent and dangerous. To an African who utilises this service, traditional medicine is seen as representing the power of the ancestors. Ancestors are seen as protectors against disease and misfortune and as alleviators of suffering (Mahape 1995:14). Mahape's view is that while people may regard witches or wizards who are trained in indigenous traditions as dangerous and malevolent, people accept traditional healers because they mediate the power of the ancestors who are the protectors of the community (Mahape 1995:14). Shai-Mahoko (1997:24) refers to Mabetoa (1992:5) who supports Mahape's (1995:14) view that one of the main reasons why traditional healers establish contact with ancestral spirits is so that they can use the wisdom of the ancestors to cure diseases and maintain health in their descendants.

2.4.1 **Biomedical health care providers versus traditional healers**

Constraints to the integration of traditional healers and biomedical personnel include a lack of information about the following:

- the number and kinds of traditional healers, their practices and their effectiveness

- current standards and controls in the practice of traditional healing, including training, recognised associations and the use of the peer review mechanism
- the projected costs for creating organisations and employing administrative staff to integrate the two approaches
- legal problems connected with the reorganisation and revision of registration requirements (Mahape 1995:15).

Troskie (1997(a):25) supports the above contentions but also notes that traditional healers give wrong information to clients/patients and that giving incorrect information is equivalent to a lack of information. At a meeting between traditional healers and the MEC for Health in Mpumalanga, the following constraints to integration were mentioned:

- working unhygienically
- giving incorrect medication
- charging high fees
- working inefficiently
- malpractice
- giving overdoses
- abusing the patient
- negligence
- causing fighting
- lack of cooperation
- overcrowding
- lack of medicine
- poor patient care

- not enough food for patients
- lack of medical report
- selfish practice
- harassment of patients
- delays in referring patients
- poor relations with patient

Although Blackett-Sliep (1989:44) mentions several advantages (such as, for example, that traditional healers are cheap and holistic), she supports Troskie's views about constraints to integration. Blackett-Sliep refers to the following perceptions of traditional healers if one looks at them from the point of view of Western medicine:

- Their medicines are not standardised.
- The instruments used by traditional healers are often not clean.
- There is friction and disagreement between traditional healers and Western doctors about the causes of disease.
- They exploit the poor and uneducated.

She confirms that research into the attitudes of traditional healers and community health nurses could be of benefit to health care consumers.

Very little is known about how to provide culture-sensitive medical and nursing care to many of the ethnic groups of South Africa because the biomedical care which is provided is modelled on the Western paradigm of patient care. Because friendly and cooperative relations are necessary if effective integration is to take place, they need to be encouraged on both sides. As mentioned earlier, all health care providers need to be sensitive and accommodating in every possible way if integration is to be achieved,

because both health care systems (the traditional and the Western) have their respective weaknesses and strengths.

The primary health care approach which was proposed at Alma-Ata advocated that first contact services and basic health care should be provided to the community – although it was recognised that some rural areas are seriously disadvantaged because health care services are simply not accessible to them (Mckenzie & Mazibuko 1989:31). Traditional healers should be seen as being able to provide first contact services for the community and so be able to bridge the gap that exists between traditional medicine and Western medicine. Collaboration between and integration of the two health care systems (leading to incorporation) should be actively encouraged and included in all future health care policies.

Both traditional healers and biomedical health care providers have particular concerns and worries about various attitudes and actions of their medical counterparts. Both sides readily identify various problems with their medical counterparts on the other side of the cultural divide. Traditional healers thus fear collaborating with biomedical health care providers because:

- they feel that too many caesarian sections are performed in hospital

- they disapprove of certain drugs such as ergometrine because it prevents patients from bleeding and so getting rid of impurities in the blood

- their patients are frequently forbidden from continuing to use herbs

which have been given to them by the traditional healer

- they feel that the handling of patients are improper

- patients are not given the opportunity to tell the doctor how they feel (nurses give this information)

The above information is confirmed by Troskie (1997(a):24) in her research paper entitled "The role of the nurse in collaborating with traditional healers in Primary Health Care clinics".

2.4.2 The community: a pillar between traditional healers and biomedical health care providers

Because the negative consequences of friction between traditional healers and community health nurses undoubtedly adversely affects the health status of the community, there is an obligation on both these parties to understand, respect and accommodate each other on health matters. Traditional medicine has existed from time immemorial and will continue to play an increasingly important role in countries like South Africa where it is traditionally established and where it is urgently needed to supplement the inadequate resources of the health care system, which are unavailable to many members of the community. Where health care services exist, whether they be traditional or Western, one needs to consider the relative affordability, acceptability, effectiveness and efficiency of such services. Since the health needs of women and children are of primary importance in any society, they are usually targeted as the primary beneficiaries of all health care systems, whether traditional or Western. In South Africa and other developing countries, the health needs of women and children, particularly those living in rural areas, are not being adequately met. Infections, malnutrition and the complications that arise out of pregnancy

and childhood illnesses continue to take a heavy toll on life. There are many reasons why this happens: the health and well-being of poor people in developing countries is adversely affected by many conditions such as inadequate or totally inaccessible health care services, insanitary housing conditions, malnutrition, overcrowding, exposure to pathogens, poverty, ignorance, and the kind of changes in the social environment that accompany industrialisation and the movement from rural areas to the peripheries of cities. There are many countries in which it will take several decades before a sufficient number of staff will be qualified to provide even basic essential health services. WHO realised all these problems before 1981 and recommended traditional birth attendants as contributors to community services (WHO:1981:7-8). After WHO had identified these problems, they were instrumental in introducing training programmes for traditional birth attendants in seven countries, namely Ecuador, Honduras, the Philippines, Sierra Leone, Sri Lanka, the Sudan and Thailand.

Although traditional healers are not specifically mentioned in the composition of basic primary health care teams, there is an urgent need to integrate them into health care systems because they act as an extended arm of community health nurses in preventing common diseases (such as, for example, HIV/AIDS, STDs, tuberculosis and the opportunistic infections that accompany HIV/AIDS) if they are properly empowered (White Paper 1997:55).

Traditional healers can become part of a referral system as they work in tandem with primary health care teams to provide continuity of care for patients. If other countries in the world are prepared to utilize the services and expertise of traditional healers in providing health care and preventing illness, South Africa should integrate traditional healers into health promotion and illness prevention programmes. Because traditional African medicine is an ancient system of medical practice which has been tried

and tested over millennia, African people have great confidence in its efficacy that is based on experience. In spite of this, traditional medicine cannot be integrated into the primary health care system without a strategy that is designed, sanctioned and approved by the Department of Health. Although a strategy of this kind would have to be embodied in a policy document, such a document can only elicit the support and approval of role players at all levels if all parties concerned are invited to express their views, hopes, concerns and opinions at all stages of policy design and implementation. Traditional healers could be successfully utilised in counselling, treatment and health education. Traditional healers, for example, could encourage the use of condoms and issue them to their clients, and counsel patients about how to avoid sexually transmitted diseases and unwanted pregnancies.

2.5 WAYS OF ASSISTING WITH THE INTEGRATION OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE.

Numerous researchers have expressed the opinion that traditional healers could be utilized in the promotion of health and the prevention of common illnesses and disorders such as HIV/AIDS, STDs, diarrhoea and vomiting, and that ways should be developed to assist in the integration of traditional healers into primary health care. Bodibe (1988:72-73) noted that the majority of her respondents favoured the use of traditional healers as consultants and advisors – especially for blacks in rural areas. In the first instance, traditional healers will have to be enlisted in pilot programmes, and a condition of their enlistment will have to be that they should be prepared to share their knowledge with all other participants in the programme. Bodibe did not describe how problems experienced by both traditional healers and biomedical health care providers were resolved.

Mahape (1995:76) and Peu (1997:8) echo the findings of other researchers when they suggest that the following measures should be implemented as steps towards resolving those problems which may be experienced when traditional healers are integrated into the primary health care system:

- Traditional healers should be legalised, i.e. the status, privileges, obligations and duties of traditional healers should be legally incorporated in terms of specific statutory legislation.

- Traditional healers should be required to undergo approved courses of training so that the safety of patients may be ensured.

Mahape (1995:77) states that a valid cultural assessment tool will have to be used to diagnose the condition of patients whose illnesses and symptoms may be culture-specific. Mahape (1995:77) refers to Ross and Cobb(1990), Haber (1987:144) and Boyce and Andrews (1989:24) and recommends that, Blocks Ethnic/Cultural Assessment Guide which may be used for the collection of cultural data, be used for formulating nursing diagnoses for further cultural management.

The realisation that traditional healers and biomedical health care providers can cooperate to solve persistent and pandemic health problems in the community is only now being fully appreciated in various quarters. It is interesting to note that Dr Schalk Loots, Director of School of Primary Health Care at the University of Pretoria, actually began a course for traditional healers but that his colleagues opposed him for wanting to cooperate with traditional healers. Dr Loots's intention was to cultivate cooperative relationships with traditional healers and offer them basic training in primary health care (e.g. how to identify tuberculosis, diabetes mellitus, diarrhoea and pneumonia). It was Dr Loots's desire to improve

the quality of health care being offered to the larger South African community that led him to make contact with traditional healers through nursing sisters working in the clinics. As a result of such contact, one hundred and twenty (120) traditional healers turned up at the meeting convened by Dr Loots. From those who attended the meeting, volunteers were selected to participate in a pioneering programme. Each participant in the programme had to have been educated to a standard five level in order to qualify as a participant (vd Linde 1997:268-272).

Early on in the meeting, some traditional healers mentioned that they could cure HIV/AIDS and tuberculosis. As the meeting progressed, the realisation dawned on some traditional healers that they do not have cures for some of the medical conditions which were discussed. All, however, began to appreciate that some form of cooperation and exchange of knowledge would benefit both themselves and Western-style medical professionals. Dr Loots did in fact design and offer a course which incorporated various components of basic health care including anatomy and physiology. The traditional healers who participated were ultimately evaluated on their performance in the course and 90% of the total number who enrolled managed to pass the examination. Dr Loots also designed a *pro forma* letter of referral for traditional healers to use when referring patients. The conclusion which was drawn from this experiment was that it is extremely valuable for traditional healers to be trained in various aspects of Western medical practice because numerous patients suffering from diseases which traditional healers cannot treat were referred by the traditional healers to biomedical health care providers (vd Linde 1997:268-272). This demonstrates that if traditional healers are sympathetically integrated into the health care system, they will be even further empowered to serve the community at a grassroots level.

While vd Linde's information was confirmed by both Peu (1997:8) and Courtright, Lewallen and Kanjaloti (1995:506), researchers expect that the training of traditional healers in basic health care will bring underlying disagreements and tensions between traditional healers and biomedical health care providers out into the open, but this is a factor which cannot be ignored and which should be appreciated and, wherever possible, resolved. If traditional healers are to be successfully integrated, differences and disagreements cannot be glossed over or ignored. All role players should be invited to express their hopes, feelings, expectations and desires if the integration of traditional healers is to be established on a firm footing. Doubts, fears and reservations can only be dealt with and resolved if participants are invited to express their problems openly and sympathetically – in the full knowledge that no sanction will be applied against those who express minority opinions.

Kelly (1995(b):112-114) emphasised that sympathetic rapport should be established between traditional healers and biomedical personnel. He also added that the following steps should be implemented by those who work with traditional healers:

- They should encourage traditional healers to become part of a meaningful support system.

- They should encourage traditional healers to participate in the provision of care.

- They should work in conjunction with traditional healers.

- They should make every attempt to understand the cultural symbols, techniques, treatments and language used by traditional healers in the treatment of their patients.

Cooperation between and integration of the two parties will strengthen the healing relationship and will ultimately benefit the community. Kelly (1995(a): 686) has identified and emphasised the importance of various activities for biomedical personnel who work with traditional healers. Kelly has also emphasised that the only way to compensate for the deficiencies of traditional healers and thus empower their medical practice is by training them in all aspects of scientific health care in which they are deficient.

Nwoga (1994:470-478) found that cancer patients frequently expressed the opinion that nurses and other health care providers are hostile, agitated and disappointing when treating their conditions. In her conclusion, Nwoga recommends that nurses in such situations should be culturally sensitive to the needs of their patients and that they should consciously act as advocates for patients who wish to choose a culture-specific form of treatment. Nwoga also emphasised that most people utilise health care services that are easily accessible and affordable to them – a fact that may be validated by means of cross-cultural research. Wherever health providers are ill-informed about cultural differences or are deficient in knowledge about the cultural needs and assumptions of their patients, health care provision always remains problematic. In such situations it is the patient that suffers the most. Only those nurses, therapists and doctors who understand the explanatory models of illness held by people from different cultures and who treat such knowledge with the respect that it deserves, can possibly hope to offer their patients efficient and humane care. The Western medical model and orientation need to be augmented by a thorough and sensitive understanding of indigenous models of illness and well-being.

In rural clinics traditional healers (traditional birth attendants) play a major role in the provision of mother and child health care. Although traditional birth attendants provided mothers with prenatal, natal and postnatal care, they need to be properly trained to be able to identify problems such as difficult labour and to manage such problems effectively (Nolte 1998:65; Itina 1997:566 & Troskie 1997(a):19). The integration of traditional healers needs to be undertaken by professionals who are sympathetic, accommodative, culture-sensitive and well-informed (Wing, Crow & Thompson 1995:61). The primary concern of such professionals should be to preserve as far as possible the traditional forms of health care practice that have been handed down since time immemorial. It is essential for those who design and construct models of integration and transcultural nursing care to take into account the research and recommendations of those theorists who have already worked in this field.

Wing et al (1995:54-61) cite the theory of Leininger as being useful for the process of learning the cultural, social and structural dimensions that influence health and health care. Leininger's theory of cultural care diversity and universality provides a methodology for planning culturally sensitive care by means of health preservation, accommodation and repatterning. Wing et al (1995: 61) further mention that the ultimate goal of nursing is to provide care that is effective while being culturally meaningful and sensitive. Integrating traditional healers into primary health care will contribute to the provision of culturally congruent health care services by the community. Traditional healers need to be accommodated in this process because they are accepted and trusted by the community. But before traditional healers can be integrated into the primary health care system, they first have to be evaluated and trained in the basics of Western medicine. Similarly, Western practitioners have to be informed and trained in the basics of traditional medicine. If Western practitioners

are ignorant about traditional medicine, they will find it difficult to respect the techniques, methods and treatments that traditional healers use.

While most traditional healers are accepted and recognised by the community for their benevolent healing practices, it is well-known that some practitioners who use the name "traditional healer" are involved in illegal and criminal activities and perform procedures that are abhorrent and unacceptable to the community – activities such as killing human beings in order to use their body parts in rituals, spells and medicine. The Sunday Times (1 November 1998) reported that Naledzani Mabunda sacrificed his baby to his ancestors. The Sunday Times of 8 November 1998 reported that a traditional healer in Mpumalanga abused a 17 year old girl – for which he was sentenced to ten years imprisonment.

If the actions of traditional healers are to be modified in the interests of their clients, traditional healers themselves need to create professional associations which have the power to set standards of ethical and professional practice. Such bodies should be vested with the statutory power to set standards, enrol members, certify practitioners, scrutinise practice, protect members, penalise transgressors and negotiate the best conditions of work and remuneration with government, medical aid schemes and other interested parties on behalf of their members. If such a professional statutory body is run by traditional healers themselves in accordance with guidelines laid down by the Department of Health, one may expect that atavistic behaviour of the kind described in the newspaper reports above may gradually be controlled and eliminated, and that all that is best in traditional medicine will be preserved, strengthened and passed intact to future generations.

An example of how traditional healers are gradually being incorporated into primary health care was mentioned. On Radio Thobela (on 6

November 1998, at 20:00) a programme discussed the involvement of traditional healers in the prevention of HIV/AIDS. This particular programme was presented after a workshop at Thoho-ya-Ndou on 6 and 7 November 1998. The theme of this workshop was HIV/AIDS and the role that traditional healers might play in its prevention. The presenter for Radio Thobela discussed these issues telephonically with a spokesperson for the traditional healers who had attended the workshop and illuminated how effective traditional healers could be by raising awareness about the incidence of HIV/AIDS and ways and means of preventing HIV infection in the community. The impression given was that traditional healers have a vital role to play in making people more aware of basic health problems. This interesting programme provided additional evidence on just how traditional healers can be used to promote health and prevent illness in the community at large.

Traditional healers have already been recognised in several provinces and are already participating in the provision of primary health care. In Mpumalanga partnerships have already been created in which biomedical doctors and health care personnel are working alongside traditional healers in newly opened clinics. These professionals work together as a team and share the knowledge and expertise which they bring from their different traditions. Ref?

2.6 SUMMARY

It is necessary for traditional healers and community health nurses to work in close cooperation with each other – preferably in multi-disciplinary teams. If the historical (but essentially artificial) differences between Western and traditional medicine are to be resolved, medical practitioners trained in Western paradigms need to be educated in traditional healing practices because traditional medicine is an inalienable part of South

Africa's multicultural society. In the same way, those who practise traditional medicine need to be educated in all the relevant points of Western medicine so that they are in a position to cooperate with Western medical professionals. The ultimate beneficiaries of this cooperation would be the public. All interested parties therefore urgently need to collaborate in the formation of properly incorporated and integrated health care teams.

The literature reviewed clarified the concepts of African's views on illness, and why traditional healers are consulted. It became clear that incorporation of traditional healing practices into primary health care has become essential. In caring for the community a humanistic cultural specific approach should be used, showing respect for each others culture.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Comprehensive information will be given in this chapter on how the study was conducted in the Odi region. The methodology used will be analysed and the method of collecting data and describing the attitudes of community health nurses towards the integration of traditional healers into primary health care will be fully explained.

3.2 RESEARCH METHOD

A non-experimental, descriptive survey was conducted to collect the data from selected community health nurses who are providing primary health care. The purpose of this study was to seek information, identify problems with current practices, justify current practices and make judgements after determining what others in similar situations are doing (Burns and Grove 1993: 293). Although the survey was costly, the approach was found to be appropriate because it was easy to explain how the questionnaire should be completed (Mahape 1995: 28). The survey allayed the fears and misapprehensions of community nurses and so they tended to be more relaxed during data collection.

3.3 POPULATION

A *population* is the entire aggregation of cases that meet a designated set of criteria (Polit and Hungler 1995:229). Subjects in this study were nurses who were registered in terms of the Nursing Act no 50 of 1978, as amended (South Africa 1978), who are providing primary health care in

Odi region of the Northwest Province. Odi region is comprised of three (3) districts, namely Odi, Brits and Moretele. Odi has twenty plus (20+) clinics; Brits has six (6) clinics and Moretele has twenty-four plus (24+) clinics. The study group consisted of black community health nurses who are providing primary health care to the community.

3.4 SAMPLING

A systematic probability sampling was chosen to select one hundred (100) respondents from the target population in Odi region. Probability sampling involves some form of random selection in choosing the elements (Polit and Hungler 1995: 231). According to Woods and Catanzaro (1988:101), every element in the population in probability sampling has a known, non-zero probability of being included in the sample and a researcher can therefore estimate the probability of each element of the population being included in the sample (hence the name). Probability sampling ensures that the sample represents the population of interests. This approach maximises the representativeness of the sample and minimises the risk of a gross distortion of estimates for the target population. It allows the researcher to estimate sampling error and permits the appropriate use of inferential statistics.

Lists of Odi region clinics were compiled. The lists were requested from Odi district clinics (23 clinics), Brits district (6 clinics) and Moretele district (24 clinics). Selection was done systematically. Each list was used individually from an individual clinic. Every second clinic was selected as a sample. Three (3) clinics were selected from Brits district; twelve (12) clinics were selected from Moretele district, and ten (10) clinics were selected from Odi district. In total, twenty-five (25) clinics were selected from fifty-three (53) clinics in Odi region. Participation was voluntary and subjects were approached directly – except in some cases where

community health nurses had the day off or were on leave. Table 3.1 reports on the number of subjects from the various areas of study.

TABLE 3.1 NUMBER OF SUBJECTS PARTICIPATING

Region	Districts	Questionnaires distributed		Number returned completed		Number returned incomplete
ODI	Odi	42	100	40	96	2
	Brits	8		8		-
	Moretele	50		48		2

Only registered nurses who are providing primary health care in clinics were included in the study because they have the experience specific to the study in question. See Appendix E, F and G for Odi region clinics.

3.5 RESEARCH INSTRUMENT

A questionnaire is a paper-and-pencil instrument that a research participant is asked to complete (Woods & Catanzaro 1988: 300). Burns and Grové (1993:368) note that a questionnaire is a printed self-report designed to elicit information that can be obtained through the written response of the subjects. It is designed to determine facts about subjects or persons known by the subjects; facts about events or situations known by the subjects, or beliefs, attitudes, opinions, levels of knowledge or intentions of the subjects.

It is self-administered (this is dependent on the accepted protocol). According to Wood and Catanzaro (1988:300), a questionnaire has the following uses:

- It identifies and explores events and meanings.
- It explores and tests relationships.

- It validates information.

See Annexure B for the questionnaire.

Structured questionnaires were used to collect relevant data from community health nurses in Odi region. Open-ended and closed-ended questions were used to collect data. Open-ended questions allow the subjects to respond in their own words whereas close-ended (or fixed alternative) questions offer respondents a number of possible replies from which the subjects have to choose the one that most closely matches (in his or her opinion) the appropriate answer.

The following types of closed-ended questions were used in the study:

- Dichotomous items which required the respondent to make a choice between two response alternatives.
- Multiple choice questions which offered more than two possible responses (Polit & Hungler 1995: 277-279). Close-ended questions limit the scope of study to the respondents.

Objectives of the study

The questions were designed to meet the following objectives:

- to identify the attitude of community health nurses towards the integration of traditional healers in primary health care.

- to identify the role of traditional healers in the community.

- to identify the constraints to integration of traditional healers in primary health care.

- to determine ways of assisting with the integration of traditional healers in primary health care.

Development of the instrument

Questions were developed by the researcher from the literature available, from radio news, newspapers, television programmes and with the help of colleagues who had experience in research design.

The questionnaire consisted of seven (7) sections. The sections were grouped according to demographical data and the objectives which the researcher had set.

The following sections were used to collect data from the community health nurses:

1. Section A: Demographical data

2. Section B: Opinions, beliefs, views and ideas about the integration of traditional healers in primary health care (closed-ended and open-ended questions were used)

3. Section C: Opinions, beliefs, views and ideas about the integration of traditional healers (statements used)

4. Section D: Opinions, beliefs, views and ideas about the integration of traditional healers in primary health care (open-ended questions were used)

5. Section E: The role of traditional healers in the community

6. Section F: Problems as constraints to integration

7. Section G: Ways of assisting with integration

Section A identified the demographical data of community health nurses and traditional healers, the community and facilities (referral hospitals and clinics). Twenty-four questions were asked in this section.

Section B, C and D identified the opinions, beliefs, views and ideas of community health nurses.

Section B consisted of twenty-two (22) questions (both open-ended and closed-ended).

Section C consisted of six (6) statements which had to be responded to by the selection of *agree*, or *disagree* or *uncertain.*

Section D required qualitative information regarding opinions, beliefs, views and ideas. Four (4) questions were asked (open-ended).

Section E comprised eight (8) items concerning the role of traditional healers in the community.

Section F consisted of five (5) items concerning the problems as constraints to integration. Both open-ended and closed-ended questions were used.

Section G consisted of six (6) items which explored ways of assisting with the integration of traditional healers in primary health care.

The questionnaire consisted of the total of ninety-seven (97) closed-ended questions and seventeen (17) open-ended questions. Thirty (30) minutes were allocated for the completion of the questionnaire. Guidelines were provided to explain how the questionnaire should be completed.

The questionnaire was the preferred medium because it could reach a large number of respondents.

3.6 DATA COLLECTION

A questionnaire was used to collect data from community health nurses. Privacy and anonymity were ensured by assigning a number to each respondent. The researcher personally distributed one hundred (100) questionnaires to the selected clinics and the respondents were given a week to complete the questionnaire as some clinics were very far away and difficult to reach. The questionnaire required thirty (30) minutes to complete. Respondents were selected from three (3) districts in Odi region. At Odi ten (10) clinics were used; at Brits three (3) clinics were used, and at Moretele twelve (12) clinics were used.

Although a number of problems arose which required new arrangements to be made, questionnaires were collected after a week. In some cases, the researcher experienced problems such as being forced to come twice or three times to the same clinic to collect the completed questionnaires.

Data collection was performed over a six week period, namely May to June of 1999. Four (4) questionnaires were sent back uncompleted because the community health nurses who were supposed to fill in these questionnaires were on leave.

3.7 PERMISSION TO CONDUCT RESEARCH

The Unisa Ethics Committee was asked to confirm that the research proposal was ethical so that the project could proceed. The committee responded positively to this request.

Permission was obtained from the District Manager of Odi region to conduct the research. The researcher personally collected a letter of permission to conduct the research from the District Manager of Odi region. (See Appendix B for the letter granting permission to conduct research.).

3.8 ETHICAL CONSIDERATIONS

A point was made of complying with principles of respect for human dignity – especially the principle of self-determination as community health nurses had the right to participate in the study or refuse to do so (Polit & Hungler 1995:122). Most of the community health nurses who were approached were willing to participate in the research because it would give them information that would help them in the future. The right to full disclosure was explained to the participants but only a few refused to participate because they were uncertain. Fairness in the selection of participants was ensured because a systematic sampling of clinics was undertaken. Only the chosen clinics participated in the study (Polit & Hungler 1995:124).

A full explanation on the purpose of the research was given to the participants. Informed verbal consent was obtained from respondents with regard to the research. The title, purpose and objectives of the research, a copy of the letter of permission from the District Manager of Odi region and a copy of the letter of permission from Unisa, all accompanied the questionnaires which were sent to the clinics.

The individual's right to confidentiality was guaranteed to all subjects (Polit & Hungler 1995:119-125). Names and addresses were not required: this was an additional way to protect the anonymity of respondents.

3.9 MEASURES TO ENSURE VALIDITY AND RELIABILITY

The subjects for a pilot study possess the same characteristics as the individuals who would compose the main sample of the study (Polit & Hungler 1995:35). The pilot study was undertaken before the main study to ensure the validity and reliability of the instrument. Only 10 percent of the total population of 100 subjects were chosen to participate in the pilot study. The pilot study was undertaken in order to identify unforeseen problems that might arise. The subjects in the pilot study did not encounter any major problems during completion of the questionnaires. A few small problems were identified and refined before the main study commenced. A correction was made to question 14 (about the number of clinics in the district). An additional plus sign (+) was added as some districts have more than eleven (11) clinics (e.g. the Odi and Moretele districts).These ten subjects were not included in the final research sample.

The research instrument was tested for face and content validity when it was given to the supervisor for acceptance. Leedy, in Raliphada-Mulaudzi (1997:39), defines *face validity* as the accuracy with which an instrument measures the factors or situations under study. The questions were thoroughly checked for any ambiguities or repetition. A professional statistician was asked to identify any irregularities that might hinder a valid analysis of the data. The statistician corrected the format of the questionnaire – especially the numbers which were used in blocks (see Annexure B). All questions were carefully phrased in simple and brief terms so as to maximise reliability and accuracy of responses.

3.10 SUMMARY

A well planned and structured methodology will guide the researcher throughout from the beginning to the end of research. All the steps of methodology should be appropriately followed.This chapter described how the research was approached . The population and sampling were identified . The structuring of the questionnaire was explained as well as data collection.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1 INTRODUCTION

The results from the study undertaken in Odi region are summarised, organised, evaluated and discussed in this chapter. Odi region is situated in the North West Province and consists of three districts, Moretele, Odi and Brits. Responses to the questionnaires are fully displayed. This chapter answers the research questions outlined in chapter one (see section 1.5). Both quantitative and qualitative data analysis were used because some statements needed amplification. The purpose of this study is to foster good relationships between traditional healers and community health nurses. This chapter consists of seven sections.

4.2 SECTION A: RESPONDENTS' DEMOGRAPHICAL DATA

This section presents crucial information about the research.

QUESTION 1: SEX OF RESPONDENTS

Demographical data was obtained through censuses, vital statistics and periodic sample surveys carried out every three months.

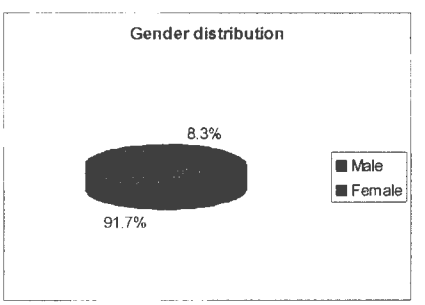

Figure 4.1: Pie graph representing gender distribution (N=96)

Figure 4.1 represents the gender distribution of the respondents who participated in the study. The gender of respondents is classified into the two categories of male and female. The gender distribution shows a great disparity between males and females: eighty-eight (91.7 %) of respondents in the study were females – as compared to eight (8.3 %) of the respondents who were males. This shows that more females are providing primary health care than males. According to Muller and Coetzee in Mahape (1995:40), male nurses registered with the South African Nursing Council comprise 6% of the total number of nurses registered. The percentage of male respondents is therefore roughly in agreement with statistics supplied by the South African Nursing Council on 31 December 1998. Registered male nurses comprise 4.7% (4,366) and registered female nurses comprise 95.3% (87,579) of all registered nurses on that date(SANC 1998).

QUESTION 2: AGE DISTRIBUTION OF RESPONDENTS

This item examines the age composition of the respondents.

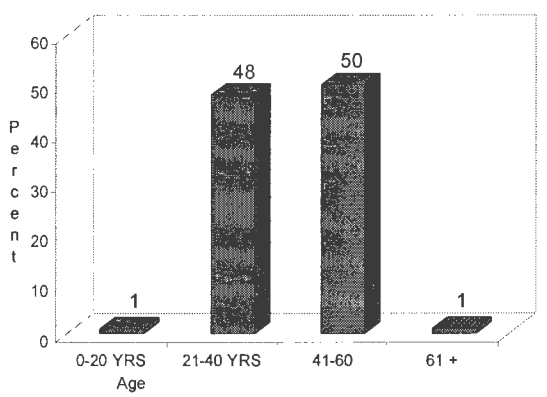

Figure 4.2: Bar graph indicating age distribution of respondents (N = 96)

Figure 4.2 shows the age distribution of the respondents. The ages of the respondents ranged between 20 and 61 years. The ages given as being between 0 and 20 years, one respondent (1.04 %) most probably reflect an error as registered nurses are appointed as community health nurses only after completion of their training. The ages of the respondents were grouped into

intervals of twenty years – except for the last category where a plus (+) category was used. The difference in age of the respondents younger than 40 years and older than 40 years was very small: 48 percent of the respondents are younger than 40 years and 50 percent are older than 40 years. This finding differs from that of Mahape (1995:41), who cites Odebiyi who found that in Nigeria 90 percent of nurses are below 34 years of age, and that the number of nurses decreases as age rises. Since more than half of the nurses are older than 40 years, it is clear that mature and experienced nurses are being allocated to the clinics where primary health care is delivered. Only one (1.04 %) of the respondents was 61+ years as at this age more community health nurses approach retirement.

QUESTION 3: MARITAL STATUS OF THE RESPONDENTS

The purpose of asking this question was to identify the marital status of the respondents because marital status can influence the attitude of respondents to integration of traditional healers in primary health care since some married women are forced by their legal husbands to consult traditional healers.

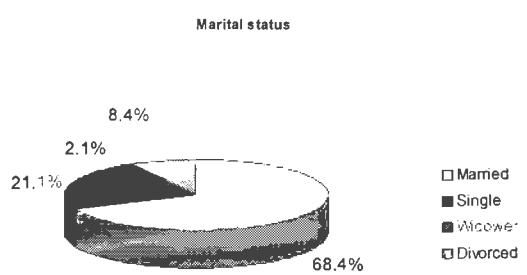

Figure 4.3: Pie graph indicating marital status of respondents (N = 96)

Figure 4.3 shows that 68.4 percent of the respondents are married, 21.1 percent are single and 10.5 percent classified as divorced or widowed. This differs from the statistics of Mahape (1995: 44), where only 46 percent of the respondents were married. The difference in the two studies could be due to the fact that Mahape's population comprised only psychiatric nurses while this study's

population comprises only community health nurses who provide primary health care. No correlation was, however, found between age and marital status. This shows that marital status and age did not have any influence on the attitude of community health nurses to the integration of traditional healers into primary health care.

QUESTION 4: RELIGIOUS AFFILIATION (CHURCH) OF RESPONDENTS

The question was asked to identify the denominations to which the respondents belong. According to Raliphada-Mulaudzi (1997:46), different churches have different norms, values and beliefs and these may influence the respondent's attitude to the integration of traditional healers into primary health care. Individuals have the right to affiliate to any church of their choice and no one should impose on their beliefs on others.

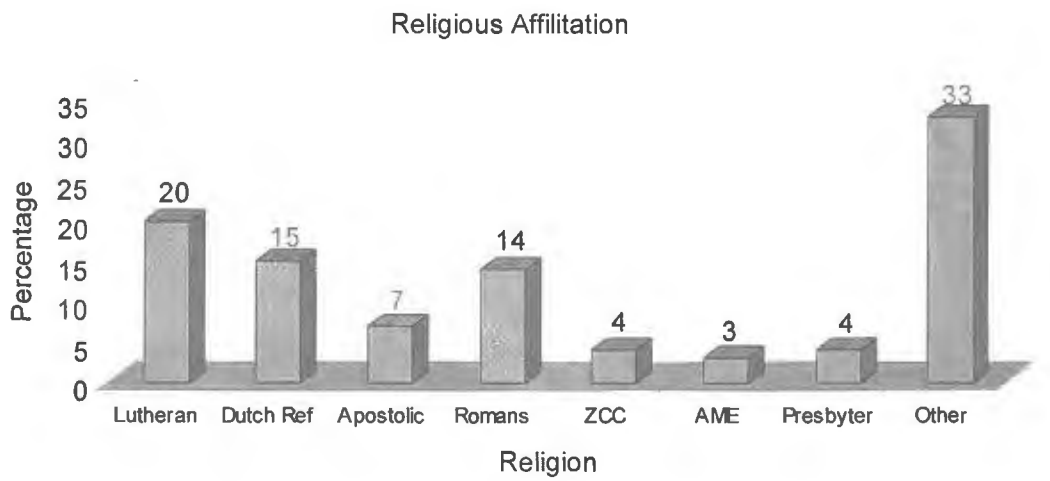

Figure 4.4: Bar graph indicating religious affiliation of respondents (N = 94)

The churches were grouped according to practices that are more or less similar. According to figure 4.4, the Lutheran, Dutch Reformed, Roman Catholic and Presbyterian Churches were the churches to which 53 percent of the respondents belong. Apostolic, Zionist Christian Church (Z.C.C.) and African

Methodist (A.M.E.) churches accounted for the religious affiliation of 14 percent of the others. Other churches mentioned accounted for thirty three percent: these were, for example, Methodist, Anglican and Modise (Pentecostal). The missing affiliation of two respondents might indicate that they have no affiliation to a church. Those churches which are more active and which therefore have a larger membership in Odi region (Odi, Brits and Moretele districts) are the Lutheran, Dutch Reformed, Roman Catholic and Presbyterian Churches. Few respondents indicated that they were affiliated to the Apostolic, Z.C.C., A.M.E. and other churches such as the Methodist, Anglican and Modise (Pentecostal) Churches. Different churches have different beliefs about healing. Christian churches are mostly opposed to traditional healing as it is viewed as witchcraft. It has, however, been noted that Africans often see traditional practices and Christianity as parallels (Troskie 1997(a):18). The fact that most of the respondents belong to a christian church could influence their attitude towards traditional healing.

QUESTION 5: ETHNIC GROUP TO WHICH RESPONDENTS BELONG

This item determined the ethnic groups in Odi region (Odi, Brits and Moretele districts) to which the respondents belong. Ethnic group could have an influence on the attitude of community health nurses towards integration of traditional healers into primary health care.

Table 4.1: Ethnic groups in Odi region (Odi, Brits and Moretele districts) (N = 96)

Ethnic Group	Frequency	Percent
Tswana	65	67.7
N sotho	12	12.6
Ndebele	4	4.2
Tsonga	3	3.1
English	3	3.1
S sotho	3	3.1
Xhosa	2	2.1
Zulu	2	2.1
Swazi	1	1.0
Venda	1	1.0
Total	**96**	**100.0**

Table 4.1 shows that the majority of respondents (65 or 67.7 %) in Odi region (Odi, Britz and Moretele districts) are Tswana-speaking, followed by 12 (12.5 %) who are Northern Sotho-speaking. Because Tswana is the most common ethnic group in the North West, the number of nurses who are Tswana probably reflects the demographic composition of the community in that area, who, one may assume, all adhere to the same value system. The table shows that the minority of respondents were composed of one Venda (1 %), one Swazi (1 %), two Xhosa (2.1 %) and two Zulu (2.1 %). The mode (value that appears frequently) was three (3.1 %) for Southern Sotho, English and Tsonga (Brink 1987: 52). The statistics show that four (4.2 %) Ndebele respondents participated in the study and that 10 languages are represented in the Odi region (Odi, Brits and Moretele districts). Afrikaans-speaking respondents were not represented. It must be noted that as the respondents were composed mostly of black nurses, they belong to sub-groups within sub-cultures which are peculiar to their own tribal life styles (Mahape 1995:42). One may assume that these nurses understand their patients in the terms of the specific ethnic groups to which they belong.

QUESTION 6: CITIZENSHIP

This question was asked in order to identify whether citizenship had any influence on the respondents's particular views and attitudes.

Of the respondents, ninety-four (100 %) are South African citizens. Two did not respond to this question. Community health nurses require culture-specific knowledge about aggregate populations in the community in order to provide culturally congruent appropriate care (Cookfair 1996:43). It is clear that the nurses in this study are able to provide cultural congruent health care in the community they serve although they come from culturally diverse backgrounds.

QUESTION 7: HOME AREA

This question elicit information about the home area of the respondents as the home area may have an influence on the attitude of respondents.

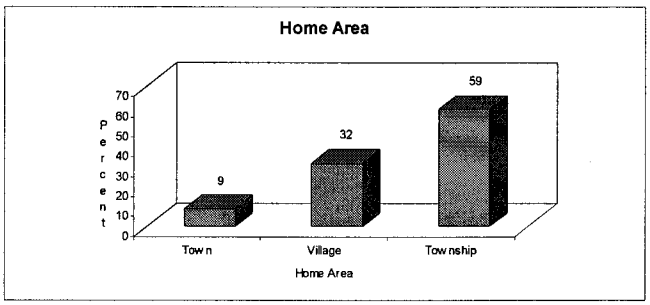

Figure 4.5: Respondents' home area (N = 94)

Figure 4.5 indicates that eight (9 %) respondents are from town; thirty one (32 %) are from a village and fifty seven (59 %) are from a township. Two percent did not respond to the question. The majority of respondents are from townships. According to Mahape (1995:43), forty two percent of the respondents in Mahape's study grew up in townships; twenty one percent grew up in villages and one percent grew up in town. The two studies display a similar distribution of respondents. As Odi region is mostly a rural area catering for townships it seems as though the nurses are from similar backgrounds and should be able to understand the cultural beliefs of the community.

QUESTION 8: NUMBER OF CHILDREN

This question was asked to identify the number of children which each respondent had because this factor may influence the attitude of community health nurses.

Table 4.2: The number of children per respondent (N = 96).

Number of children	Frequency	Percentage
0-2	47	49.0
3-4	42	43.8
5-8	7	7.2
Total	**96**	**100.0**

The majority of community health nurses in this study as displayed in table 4.2, i.e. 47 (49 %), have 0-2 children; 42 (43.8 %) have 3-4 children and 7 (7.2 %) have 5-8 children. According to the statistics released by the Department of Health, black women have a high fertility rate of 4.3 percent compared to white women who have a fertility rate of 1.6 percent (Department of Health1997:21). In 1994, the average number of children born to for black women was 4.3. According to figure 4.2, almost half (49.5 %) of the respondents are still of child-bearing age: this is congruent with the percentage of those who have fewer than 2 children.

QUESTION 9: HIGHEST STANDARD PASSED

Table 4.3: Highest standard passed by respondents (N = 90)

Highest standard passed	Frequency	Percentage
Std 7-10	50	55.6
Post secondary	40	44.4
Total	**90**	**100.0**

According to table 4.3, all respondents had either passed standard 7 to 10 or had obtained a post-secondary qualifications. Six did not respond to the question. Fifty 50 (55.6 %) had passed standard 7-10 whereas forty four (44.4%) had obtained a post-secondary qualification. Education plays a mayor role in

determining attitudes towards the integration of traditional healers into primary health care (Raliphada-Mulaudzi 1997:47). It should be noted that in order to qualify as a professional nurse trainee, an applicant requires a standard 10 certificate, and that a nurse's training comprises four years of post-secondary school study. It could be that the respondents understood "post secondary" to mean an additional qualification and that the 55.6 percent who said that they had only standard 10 should really also be included in the post secondary group. This question therefore contains a limitation in that it might reflect a misunderstanding.

QUESTION 10: PROFESSIONAL QUALIFICATION

A professional qualification has a major influence on the attitudes of nurses. This question determined the different professional qualifications possessed by the community health nurses and sought to determine whether such qualifications influenced their attitudes towards the integration of traditional healers.

Table 4.4: Professional qualifications of respondents (N = 96)

Qualifications	Yes	
	Frequency	%
General nurse	96	100
Midwife	67	69.8
Community health nursing	40	41.7
Psychiatry	20	20.8
Other	26	27.1

According to table 4.4, 96 (100 %) respondents indicated that they are registered general nurses. This clearly indicates that the respondent who indicated that she was between 0-20 years made a mistake , as to be registered as a nurse you need four years post school training. This is followed by 67 (69.8 %) who have a midwifery qualification; forty (41.7 %) who have a community health nursing qualification and 20 (20.8 %) who have a psychiatric nursing qualification. Of the respondents, 26 (27.1 %) have other qualifications in areas such as paediatrics and health service management. It is a matter of some concern that twenty nine (30.2 %) did not have a midwifery qualification. It is also important to note that

fifty six (58.3 %) did not have a community health care nursing qualification and that seventy six (79.2 %) did not have a psychiatric nursing qualification. This might be attributable to the fact that these nurses completed their training before the comprehensive course commenced in 1983 – after which general nursing and midwifery qualifications became compulsory under the new registration regulations. They might also be enrolled nurses who did the bridging course. Most community health clinics provide maternity care and if nurses do not have midwifery and community health nursing qualifications, effective care will not be possible. The high percentage (79.2 percent) who do not have a psychiatric nursing qualification is a cause for alarm. Bodibe (1988:87) indicated that traditional healers should cooperate with mental health teams in order to share their knowledge and skills. If nurses do not have psychiatric nursing qualifications, it might well be difficult for them to distinguish between good and bad practices.

QUESTION 11: YEARS OF EXPERIENCE COMBINED WITH
QUESTION 12: DISTRICT OF WORK

Community health care nursing experience has a major influence on attitudes towards healing and health care because years of experience in community health care nursing is an important determinant of attitudes towards the integration of traditional healers into primary health care. These two questions were grouped together because district of work and years of experience may have an influence on each other.

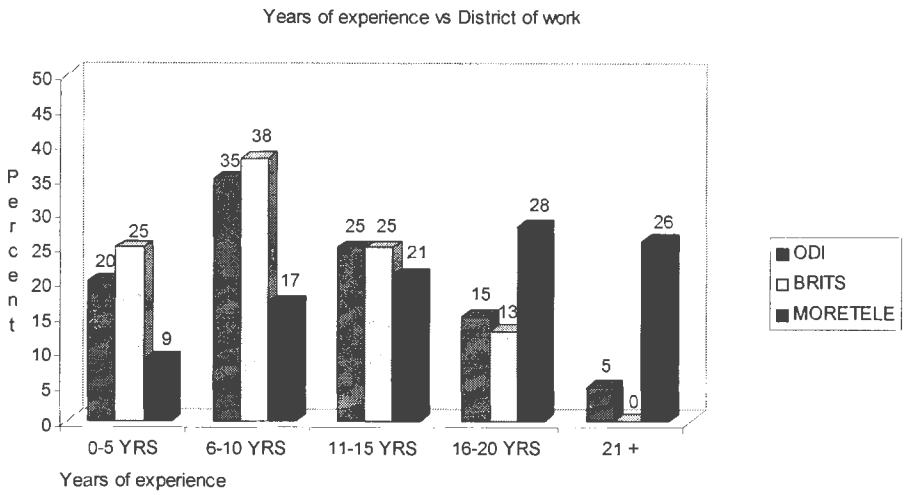

Figure 4.6: Years of experience vs district of work (N = 96)

Figure 4.6 correlates the relationship between years of experience and district of work. A significance of 0.35564 (< 0.05) between years of experience and district of work indicated that years of experience had no influence on the district of work. The Moretele district represented the highest percentage (49.5 %) of respondents, followed by Odi with 42 percent. Brits was only represented by 8.5 percent of the respondents. According to figure 4.6 most of the respondents from Odi (36 %) and Brits (38 %) had between 6-10 years experience. At Moretele the highest percentage (28 %) had between 16-21 years experience. Moretele is the district where nurses had the most experience: 75 percent had more than 11 years experience. This is followed by Odi, where 45 percent had more than 11 years experience. Brits had only 38 percent respondents with more than 11 years experience. This could also be due to the fact that only 8,5 percent of the respondents came from the Brits district.

QUESTION 13: DISTANCE FROM CLINIC TO REFERRAL HOSPITAL

Distance from a referral hospital might influence community members to consult traditional healers. According to Dennil, King and Swanepoel (1999:6), primary health care should be accessible, affordable, available, effective and efficient and

all people should have equal access to basic health care. A clinic should be within 15 km of where the patient lives if it is to be regarded as accessible.

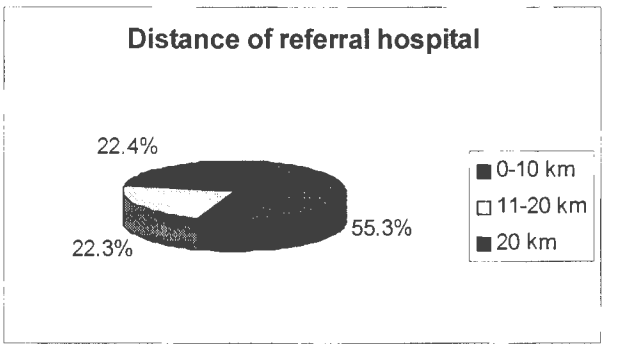

Figure 4.7: Pie graph indicating distance of referral hospital (N=96)

Figure 4.7 represents the distance of the clinics to referral hospital. According to this figure, 55.3 percent of the respondents indicate that clients from the region of Odi (Odi, Brits and Moretele) travel from 0-10 km to reach the clinic – which indicates that most clinics are providing accessible primary health care; 22.3 percent of the respondents indicate that clients travel from 11-20 km from the clinic to the referral hospital, and 22.4 percentage travel more than 20 km, which is too far a distance to comply with the definition of acceptable primary health care provision. Dennil et al (1999:6) have recommended that the services of primary health care should be extended to be within reasonable reach of all people (i.e. within a distance of 5-10 km). It is estimated that almost half of the clinics are more than 10 km from the hospital and that if transport is not available, this renders them inaccessible to patients. The distance from the clinic to the referral hospital may have an influence on a patient who is referred from the clinic to the referral hospital. Although clinics provide accessible primary health care, certain clients might still wish to consult traditional healers because of the possibility of other modes of payment.

QUESTION 14: NUMBER OF CLINICS PER DISTRICT

The researcher asked this question to determine the likelihood of members of the

community consulting traditional healers because of an insufficient number of clinics. Only Brits had fewer than eleven (11) clinics in the district (Brits district has only 6 clinics in all). After sampling, three clinics were selected from a total of six clinics. Both Odi and Moretele had more than eleven clinics in their districts. The difference in the number of clinics may be attributed to the size of the district or the density of the population. As only eight respondents were from the Brits district, the implication might be either that Brits is the smallest district or else that it has the highest population density and larger clinics.

QUESTION 15: THE NUMBER OF COMMUNITY HEALTH NURSES PER CLINIC

The number of community health nurses may influence the attitude of community health nurses towards integration of traditional healers into primary health care.

Table 4.5: Number of community health nurses per clinic (N = 96)

Number of community health nurses	Frequency	Percentage
1-5	43	44.8
6-10	27	28.2
11-15	10	10.4
16-20	6	6.3
21 and above	6	6.3
Total	**96**	**100**

Table 4.5 indicates that 43 (44.8 %) of the respondents indicate that 1-5 nurses are allocated per clinic. Only twelve (12.6 %) of the clinics had more than 16 nurses allocated to them. The number of nurses per clinic may have an influence on the rate at which clients consult clinics. Fewer nurses per number of clients could affect the rate of client consultation. If clients feel that they have to wait too long to be seen at clinics, they might prefer to consult traditional healers.In a telephonic conversation with the Director of Health Services (Odi region) (October 2000) about the allocation of nurses per clinic, he indicated that the allocation of nurses to each clinic is based on population statistics and the perceived average workload of nurses in clinics. This means that more nurses are allocated to busy clinics while fewer nurses are allocated to clinics with a

lighter average workload.

QUESTION 16: THE TYPE OF COMMUNITY

It is important to determine the views, opinions and beliefs of a multicultural rural or urban community.

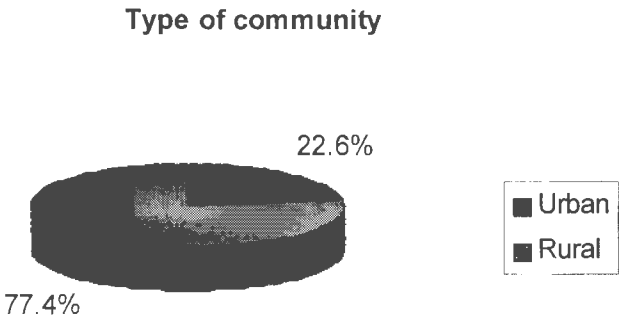

Figure 4.8: Pie graph indicating the type of community to which services are rendered.

According to figure 4.8, the majority of the communities (77.4 %) are rural. The World Book Dictionary (1994:1825) defines *rural* as "belonging to the country or like that of the country". If 77.4 percent of the community nurses are rendering service to rural patients and 22.6 percent are rendering services to urban communities, the different beliefs and attitudes of the patients should be taken into account. People from an urban community more frequently come into contact with Western culture and beliefs.

QUESTION 17: STATISTICS OF APPROXIMATE NUMBER OF DAILY ATTENDANCES FOR MINOR AILMENTS

QUESTION 18: STATISTICS OF APPROXIMATE NUMBER OF MONTLY ATTENDANCE FOR PSYCHIATRIC PATIENTS

QUESTION 19: STATISTICS OF APPROXIMATE NUMBER OF MONTHLY ATTENDANCE FOR TUBERCULOSIS (TB) PATIENTS

Question 17, 18 and 19 were combined as they provide the statistics which indicate the rate of attendance at the clinic.

According to figure 4.9 in the three districts combined, 89.2 percent have more than 50 patients attending the clinic with minor aliments and 63.4 percent have more than 50 patients attending the clinic with psychiatric problems. It is interesting to note that with the high prevalence of TB in South Africa, only 11.1 percent indicated that more than 50 patients with TB attended the clinic.

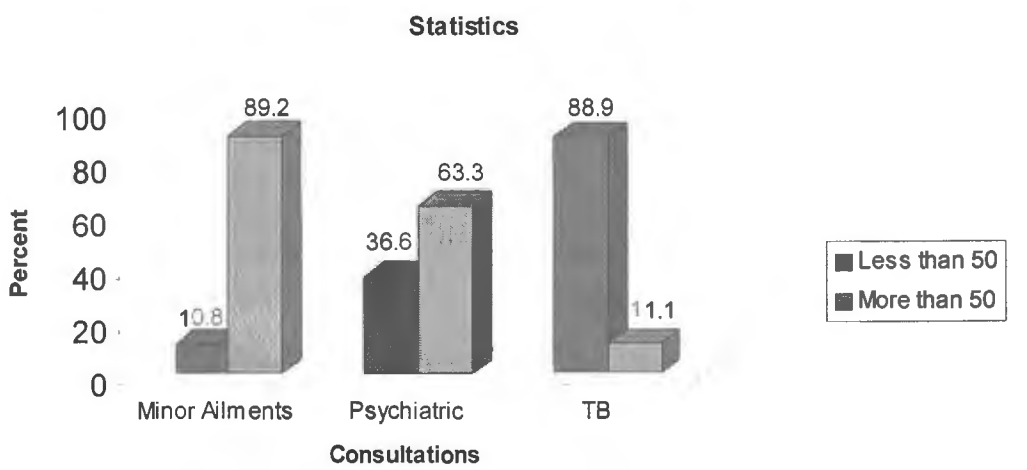

Figure 4.9: Statistics of minor ailments, psychiatric and TB patients per clinic (N=96)

According to recent research conducted on TB, South Africa has a total TB population of 86,950 in the nine provinces. Of the nine provinces in the Republic of South Africa, North West Province is sixth in ranking order with regard to the prevalence of TB: North West Province has a TB patient population of 5,594.

This could account for the smaller percentage of TB patients attending the clinics (Department of Health 1999:10).

QUESTION 20.1 STATISTICS OF PSYCHIATRIC DEFAULTERS
QUESTION 20.2 STATISTICS OF TB DEFAULTERS

This question was asked to determine the number of defaulters in Odi region (Odi, Brits and Moretele districts). Traditional practices may contribute to the incidence of defaulters. A "defaulter" is someone who fails to do something that he or she is supposed to do, such as failing to take treatment (Sinclair, Fox, Moon, Yuill, Hewings & Watson 1993:137).

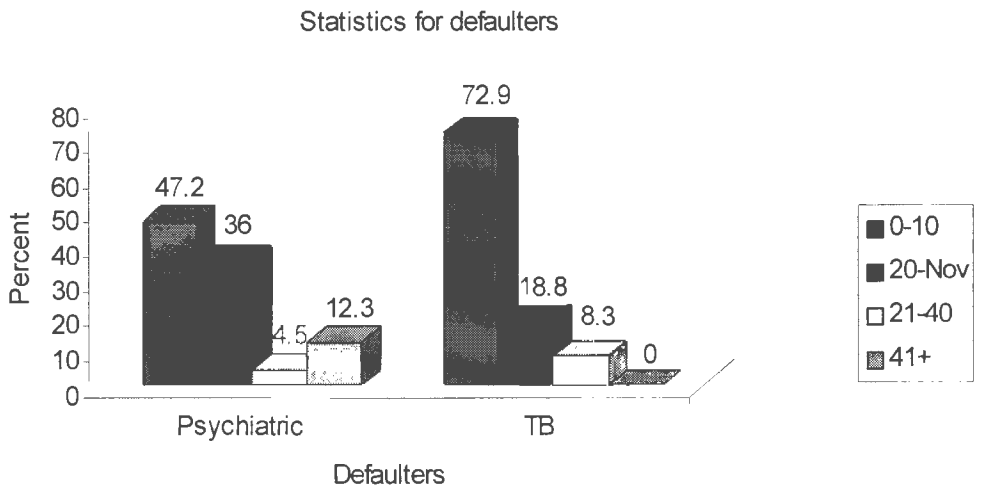

Figure 4.10: Bar graph representing the statistics of defaulters (N = 96)

It is encouraging to note from figure 4.10 that the majority of TB patients do not default because 72.9 percent of the respondents reported only between 0-10 defaulters while 18.8 percent reported between 11-20 and 8.3 percent reported between 21-40. With mentally ill patients the picture is not as good because 12.3 percent of the respondents reported more than 41 defaulters while 4.4 percent reported between 21-40 and 36 percent reported between 11-20. Only 47,1 percent reported 10 defaulters. When it is taken into account that only 57.1

percent of the respondents have a qualification in psychiatric nursing (see table 4.5), this might be part of the problem because nurses without the psychiatric nursing qualification might not possess the ability to impress upon their patients who present with mental disturbances the importance of follow-up treatment.

QUESTION 21: TYPE OF CLINIC SERVICE RENDERED

It was necessary to identify the types of clinic services rendered in clinics since this might influence rates of attendance at the clinic.

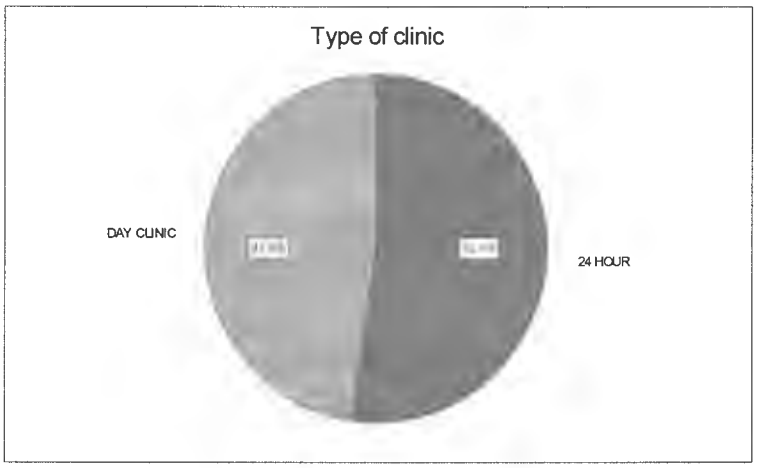

Figure 4.11: Bar graph indicating the type of clinic service (24-hour or day clinic) (N = 96)

The majority (52.1 %) of clinics (as can be seen from figure 4.11) provide a 24-hour service and 47.9 percent of the clinics are providing only day clinic services. The fact that some clinics only offer a day service might influence clients to consult traditional healers – especially during the night. If the clinic closes during the night, patients might prefer to consult traditional healers because they are available and accessible.

QUESTION 22: SERVICES PROVIDED

The services in the community should be affordable, available, accessible, acceptable and attainable so that the needs of the community may be met. The type of services provided also influence clinic attendance. If certain services are not offered, members of the community may be influenced to consult traditional

healers.

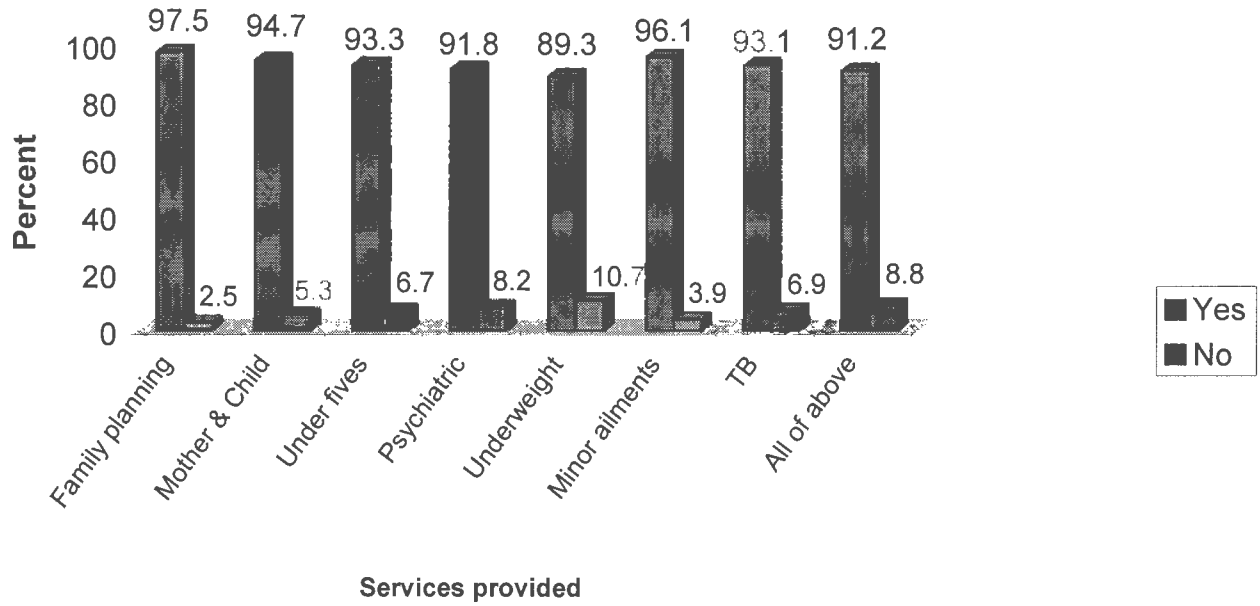

Figure 4.12: Bar graph representing services provided (N = 96)

Almost all the clinics (91.2 %) – as can be seen from figure 4.12 – provide comprehensive primary health care. This includes the following services: family planning, mother and child care, under-five care, psychiatric health care, underweight counselling, minor ailments and treatment for tuberculosis (TB). The majority of clinics (97.5 %) provide family planning services. This is encouraging because it contributes to quality of life of the population.Of the clinics 89.3 percent provide services for underweight babies: this reflects the lowest percentage of all the services. Only a few clinics (8.8 %) do not provide comprehensive primary health care. There is a very high correlation (1,0000, P= 0000) between services provided (especially family planning services) and minor ailments. Almost all the clinics that are providing family planning also provide services for minor ailments. There are also correlations between all services provided. With under-five care and psychiatric services, a correlation of .9060, (P = 0000) was identified. This is significant because a high correlation is an

indication that all services are intertwined. At clinics, clients receive comprehensive services such as, for example:

- family planning for a breast-feeding mother
- immunization for babies as well as treatment for babies who are underweight because of malnutrition.

QUESTION 23: DO YOU HAVE TRADITIONAL HEALERS IN THE COMMUNITY?

This question presented an opportunity to enquire about the presence of traditional healers because traditional healing may influence health promotion and illness prevention.

Table 4.6: Presence of traditional healers in the community (N = 96)

Value label	Frequency	Percent
Yes	95	99
No	1	1

Table 4.6 shows that the majority of community health nurses (99 %) know that traditional healers live and work in the community. Only 1 percent indicated that there were no traditional healers in the community. This indicates that traditional healers are practising in all three districts and community health nurses will continue to treat patients who have consulted a traditional healer. The respondent who indicated "no" to the statement might be influenced by her beliefs or else it is possible that this respondent has had no contact with patients who had consulted traditional healers. According to Bodibe (1988:90-91), traditional healers should be included in mental health care teams as part of primary health care delivery systems. This would benefit clients who prefer to use both kinds of health care system. Shai-Mahoko (1997:66) believes that the role of traditional healers is to promote the physical and mental well-being of the community. This could be achieved through cooperation among traditional healers and formal health care workers.

QUESTION 24: TYPES OF TRADITIONAL HEALERS IN THE COMMUNITY OF ODI REGION (ODI, BRITS AND MORETELE DISTRICTS)

It is very important to determine the various types of traditional healers as different healing practices may influence primary health care provision.

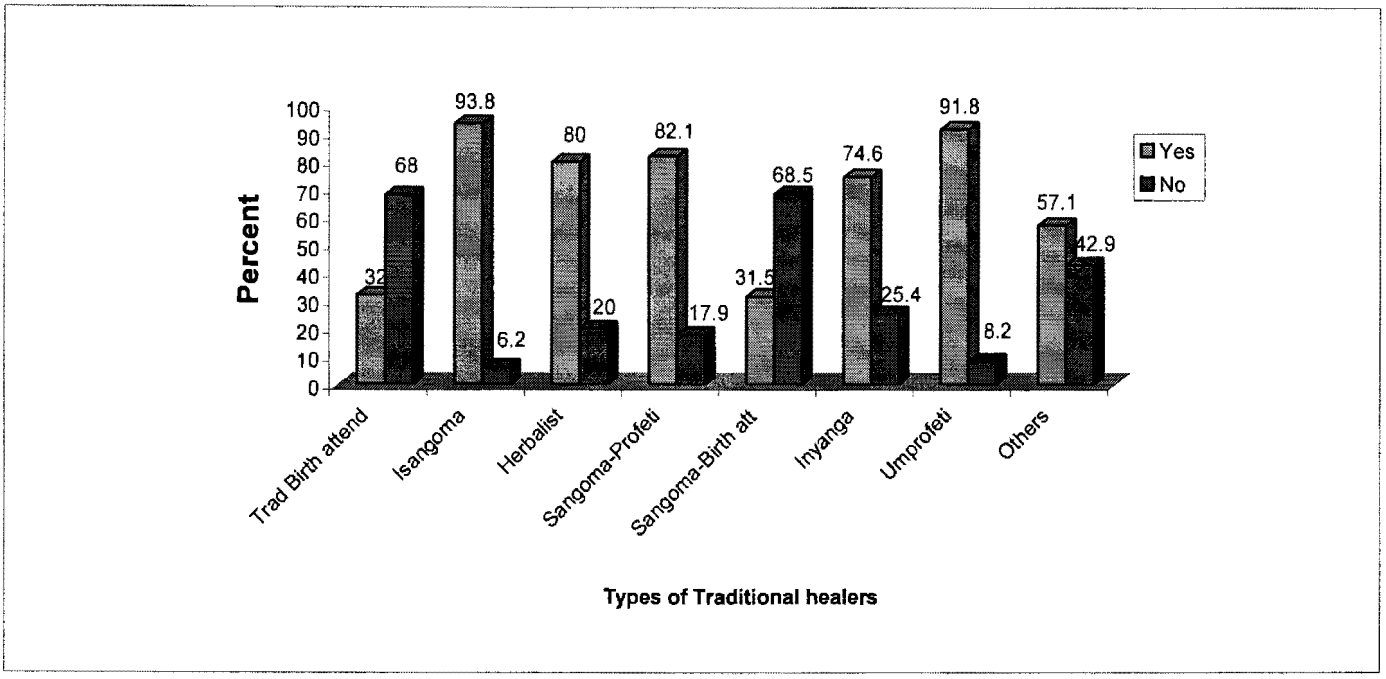

Figure 4.13: Types of traditional healers in Odi region (N=96)

Figure 4.13 shows that 93.8 percent of the respondents identified *isangoma* as the type of traditional healer in the region. This was followed by *umprofeti* (91.8 %); 82.1 percent for *sangoma profeti* and 80 percent for *herbalist*. There are fewer sangoma-birth attendants and traditional birth attendants in the Odi region (Odi, Brits and Moretele districts). Of the respondents, 68.5 percent indicated that sangoma-birth attendants are not present in the community, while 57.1 percent of the respondents indicated that other traditional healers, namely *spiritual healers*, work in the community. There is a slight difference in the rate of incidence of *umprofeti* and *spiritual healers*. The high correlation of 7983 =p000 between traditional birth attendants and sangoma-birth attendants indicates that

birth attendants are utilized equally by the community as their healing practices do not differ. *Isangoma* and *umprofeti* are also consulted equally and this indicates that there is a high correlation (17093) between the two types of healers.

4.3 SECTION B: OPINIONS, VIEWS AND IDEAS

This section is important because it identifies the different opinions, views and ideas which community health nurses have about the integration of traditional healers into primary health care. The differences in opinions, views and ideas among community health nurses influence their attitudes towards integration. (N = refers to the number of respondents that answered a specific question.)

QUESTION 1: DO PATIENTS IN YOUR AREA CONSULT TRADITIONAL HEALERS?

QUESTION 2: DO MALE PATIENTS CONSULT TRADITIONAL HEALERS MORE FREQUENTLY THAN FEMALE PATIENTS?

QUESTION 3: DO OLDER PATIENTS CONSULT TRADITIONAL HEALERS MORE FREQUENTLY THAN YOUNGER PATIENTS?

These questions were asked to determine what the community health nurses had to say about the frequency with which their patients consult traditional healers. The indication is that patients – irrespective of age or sex – consult traditional healers. Table 4.7 indicates the frequency with which various patients consult traditional healers.

Table 4.7 Consultation of traditional healers

Opinions, views and ideas	Yes		No		Total	
	Frequency	%	Frequency	%	N	%
Do patients in your area consult traditional healers?	94	97.9	2	2.1	96	100
Do male patients consult traditional healers more frequently than females?	59	67	29	33	88	100
Do older patients consult traditional healers more frequently than younger patients?	74	80.4	18	19.6	92	100

Table 4.7 shows that the majority of respondents (ninety-four, i.e. 97.9 %) agreed that their patients consult traditional healers, while fifty-nine (67 %) of the respondents agreed that male patients consult traditional healers more frequently than female patients. Question 3 revealed that seventy-four (80.4 %) of the respondents indicated that older patients consult traditional healers more frequently than do younger patients.

When patients are ill they consult traditional healers for treatment because it is part of their culture to do so. Very few respondents disagreed with the statements. Two respondents (2.1 %) replied negatively to question 1; twenty-nine (33 %) of respondents replied negatively to question 3, and eighteen of respondents (19.6 %) disagreed with the statement that older patients consult traditional healers more frequently than do younger patients.

QUESTION 4: COMMON DISEASES FOR WHICH PATIENTS CONSULT TRADITIONAL HEALERS

Table 4.8 Common diseases for which patients consult traditional healers

Condition	Frequency			
	Always	Seldom	Never	Total N =
Diarrhoea/Vomiting	75 (79.8%)	17 (18.1%)	2 (2.1%)	94 (100%)
High blood pressure	17 (18.9%)	61 (67.8%)	12 (13.3%)	90 (100%)
Diabetes Mellitus	13 (15.2 %)	58 (67.4%)	15 (17.4%)	96 (100%)
Psychiatric illness	85 (89.5%)	8 (8.4%)	2 (2.1%)	95 (100%)
Other (specify)	44 (83.0%)	6 (11.3%)	3 (5.7 %)	53 (100%)

Table 4.8 shows that 85 respondents (89.5%) agreed that their patients consulted traditional healers for mental illness. This means that mental illness is

the condition for which patients most frequently consult a traditional healer. Seventy five (79.8%) of the respondents asserted that their patients consulted traditional healers when they suffered from diarrhoea and vomiting. Only 53 respondents responded to other and the conditions mentioned here were HIV/AIDS, tuberculosis, sexually transmitted diseases and skin conditions. Of these 53 respondents, 44 (83.0%) indicated that the conditions mentioned were always taken to a traditional healer.

These findings confirm the research of Shai-Mahoko (1997:116), who mentioned that indigenous healers are able to treat and prevent *"phogoana"* (diarrhoea and vomiting) and that Western and indigenous healers together are able to treat mental illness.

QUESTION 5: HOW MUCH DO PATIENTS PAY FOR CONSULTING TRADITIONAL HEALERS?

Table 4.9 Amount of payment made by patients to traditional healers (N = 92)

Payment	Frequency	%
R1 – R100	31	33.7
R101 – R500	37	40.2
R501 – R1000	16	17.4
R1001 +	8	8.7
Total	**92**	**100**

Table 4.9 shows that 37 (40.2%) of the respondents pay a fee of R101-R500 for consulting a traditional healer. Only thirty one (33.7%) pay between R1-100. The rest twenty-four (26.1%) pay more than R500. This is alarming because consulting a traditional healer is far more expensive for the majority of respondents than Western-style medical treatment. Bodibe's (1988:61) study indicates that fees for consulting traditional healers is between R5-R200. Because this research was carried out ten years ago, it is probable that fees are now higher than those which Bodibe identified.

QUESTION 6: WHAT OTHER KIND OF PAYMENT CAN PATIENTS MAKE?

This question was asked to identify the various forms of payment which patients might be asked to make for consultation. Different kinds of payments are identified because some traditional healers require quite specific kinds of payment (i.e. forms of payment other than money). Note that respondents were able to answer positively to more than one option.

Table 4.10: Kind of payment made by patients (N = 96)

Kind of payment	Frequency	%
Cattle (cows and bulls)	64	67
Goats	59	61.4
Sheep	34	35.4
Chicken	34	35.4
Money	14	14.6
Children (daughters – virgins)	11	11.5
Groceries	7	7.3
Cars	6	6.3
Women	2	2.08
Work as a servant if money not available	2	2.08
African meal	2	2.08
Africa sorgum Beer	1	1.04
Presents	1	1.04
"Thanks giving" (expression of gratitude)	1	1.04
Human body parts	1	1.04

Table 4.10 shows that the majority of respondents (64 or 67%) indicated that cattle are used as the means of payment for consulting traditional healers. If 67 percent of the respondents identified cattle as the kind of payment which traditional healers preferred, it follows that the patients themselves either possess cattle or are able to buy them. Rural communities farm with cattle and so it makes sense that they are able to use them as a form of currency with which to pay for consultations with traditional healers. The second most common payment is goats, which were mentioned by 59 (61.4%) of the respondents. This is followed by 34 (35.4 %) who indicated that they pay by giving a sheep or chicken.

If the equivalent monetary value of goats, sheep, chicken, a cow or cattle is considered , it becomes clear that consulting a traditional healer is much more expensive than a visit to a clinic in the North West Province because no charge is made for visits to clinics in the North West Province. Cattle are the most expensive animals of those used as a form of currency for paying for consultations with traditional healers because they are the largest domestic animals which a person can own. Because of this they are also the most acceptable form of payment to the traditional or spiritual healer (Kriel 1989:137).

Although only 1 (1.04 %) mentioned human parts, it is unethical and against the laws of this country for a person consulting a traditional healer to use human parts as payment. This kind of practice (trade in human parts and the use of human parts as forms of payment for consultation with traditional healers) blackens the name of traditional healers and causes members of community to distrust, fear and hate them. Similarly, to use children and women as a form of payment instils feelings of fear and hatred in the community. According to South African law it is a criminal offence to barter in human beings and sell them into servitude. This was mentioned by 11 (11.5 %) and 2 (2.08 %) respondents respectively. Other methods of payment are also shown in table 4.10.

QUESTION 7: METHODS OF EXAMINATION

The methods of examination may influence the integration of traditional healers into primary health care. Table 4.11 shows that respondents identified several methods of examination by traditional healers. The methods will affect the provision of primary health care. Patients might prefer the methods of examination (such as the bones) that will give them a swift explanation of their condition. A method such as this might influence clients to consult traditional healers because they, the clients, are given immediate insight into their health problems.

Table 4.11: Methods used by traditional healers to examine their patients (N = 96)

Methods of examination	Frequency	%
Bones	93	96.8
Bible	47	49
Mirror	40	41.7
Water	32	33.3
Spiritual method	14	14.6
Prayer	7	7.3
Cards (*Dikarata*)	5	5.2
Snuff	5	5.2
Prophesying	5	5.2
Healing sticks	3	3.1
Candle	3	3.1
Robes	3	3.1
Words from ancestors	2	2.08
Tea leaves	2	2.08
Dollars	1	1.04
Inoculation	1	1.04
Hypnotic Muti	1	1.04
Didupe/Mankgwenyana = "senses"	1	1.04
Animal blood	1	1.04
50c coin	1	1.04

Of the respondents, 93 (96.8 %) indicated that traditional healers use the bones to diagnose their patients' ailments. The second most frequently used method of diagnosis, mentioned by 47 (49 %) of the respondents, is the use of the Bible (usually used by "umprofeti") during consultation. Forty respondents (41.7 %) said that a mirror was used as a means of diagnosis. Thirty-two respondents (33.3 %) said that traditional healers used water to diagnose the illnesses of their patients. Water is seen as the sustainer of life because every human being emerges from water (Kriel 1989:2). Traditional healers use this life-giving element to divine the condition of their patients. Traditional healers who use a mirror combine it with traditional muti (such as some plants substance) to drug the patient. A few respondents indicated the use of hypnotic muti, the use of dollar, inoculation, animal blood and the use of a 50c coin.

QUESTION 8: DO YOU FEEL COMFORTABLE WITH METHODS OF EXAMINATION USED BY TRADITIONAL HEALERS?

QUESTION 9: IF NO, SUPPORT YOUR STATEMENT.

These questions were important to determine the degree of confidence which the community health nurses had in the methods of examination used by traditional healers. Most of respondents, i.e. fifty-eight (61.1%) did not feel comfortable with the methods used by traditional healers to examine patients.

According to table 4.12 the majority twenty-two (22.9%) of the respondents who did not feel comfortable with methods used mentioned that it was guesswork because they use bones for examination. "How can a bone diagnose what is wrong with the patient when it is an object?" was a question which was asked. The same percentage of community health nurses indicated that patients come to the clinic with complications which they linked to the use of bones as a method of diagnosis.

Table 4.12: Displayed reasons to support "no" statement. (N = 95)

Do you feel comfortable with methods of examination of traditional healers?	Yes		No		Reason given to support no Statement	F	%
	F	%	F	%			
	37	38.9	58	61.1			
					Traditional healers use guess work	22	22.9
					Patients come with Complications	22	22.9
					Traditional healers are unreliable	10	10.4
					Traditional healers are Unhygienic	10	10.4
					Blame others for witchcraft	5	5.2
					Traditional healers are Inaccurate in examination	4	4.2
					Conditions are delayed.	2	2.08
					Traditional healers make a lot of noise, funny sounds and actions.		
					They are not scientific.	1	1.04
					Only God knows.	1	1.04
					Traditional healers fear nurses.	1	1.04
					I do not belief in traditional healers.	1	1.04
					They use wrong physical examination.	1	1.04

Another group of ten (10.4 %) respondents indicated that traditional healers are unreliable in their methods of examination. The use of a mirror for diagnosis may not be a reliable method. Ten (10.4 %) of the respondents felt that traditional healers used unhygienic methods of examination and cited this as a reason for them feeling uncomfortable. Table 4.12 shows that respondents cited other reasons for feeling uncomfortable with the methods of diagnosis and examination by traditional healers. These other reasons included the assertion that traditional healers blame others for witchcraft, that their diagnoses are inaccurate and unscientific and that only God knows certain things. According to Mvuyo (1992:28), members of the community consult and visit traditional healers as a result of pressure from their relatives and/or friends who believe that witchcraft is the cause of disease.

QUESTION 10: WHAT ARE THE COMMON METHODS OF TREATMENT USED BY TRADITIONAL HEALERS?

The methods of treatment used by traditional healers play a major role in society. Traditional healers use different methods in treating their patients that may influence the healing of patients.

Table 4.13: The most common methods of treatment used by traditional healers

Method of treatment	Always		Sometimes		Never		Not applicable		Total	
	F	%	F	%	F	%	F	%	N	%
Oral	86	92.4	5	5.4	1	1.1	1	1.1	93	100
Steam inhalation	51	55.4	38	41.3	2	2.2	1	1.1	92	100
Rectal	40	46.1	41	47.1	1	1.1	5	5.7	87	100
Inoculation	39	47.6	29	35.4	2	2.4	12	14.6	82	100
Spiritual	38	46.3	32	39.1	5	6.1	7	8.5	82	100

According to table 4.13, 86 (92.4 %) of the respondents indicated the oral method as the method of treatment that is always used by traditional healers. This was followed by steam inhalation cited by 51 (55.4 %) of respondents, rectal medication cited by 40 (46.1%) of respondents, inoculation cited by 39 (47.6 %)

of the respondents, and spiritual healing which was cited by 38 (46.3 %) of the respondents. Blackett (1989:129) confirms that traditional healers give *imbiza* to drink. *Imbiza* is a selection of herbs and/or other medicinal ingredients which are mixed with water and are then administered orally (Blackett 1989:84). Of the respondents, only one indicated that traditional healers never use either the oral method or the rectal method. This shows that traditional healers almost always use oral treatments or steam inhalation, and that inoculation, rectal and spiritual healing are methods that are less commonly used.

QUESTION 11: HAVE YOU EVER CONSULTED PATIENTS REFERRED FROM TRADITIONAL HEALERS?

QUESTION 12: DO PATIENTS BRING ALONG A REFERRAL NOTE?

These two questions were combined as they determine patterns of referral of patients from traditional healers to clinics.

Table 4.14: Referral of patients from traditional healers to the clinics (N = 96)

Referral statement	Yes		No		Total	
	Frequency	%	Frequency		N	%
Have you ever consulted patients referred from traditional healers?	78	81.2	18	18.8	96	100
Do patients bring along a referral note?	6	6.2	90	93.8	96	100

According to table 4.14, 78 (81.2 %) of the community health nurses have consulted patients referred by traditional healers for replacement of fluids. Table 4.14 also makes it clear that the majority of respondents (i.e. 90 or 93.8 %) indicated that they consulted patients referred from traditional healers without a referral note. It is evident that the majority of patients are referred from the traditional healers without a referral note.

QUESTION 13: DO PATIENTS CONSULT THE CLINIC WHEN ILLNESSES ARE AT AN ADVANCED STAGE?

QUESTION 14: IF YES, GIVE REASONS.

If the answer to question 13 (on whether the community health nurse has ever consulted a patient in the clinic who presents with an illness at an advanced stage), was **yes**, the respondent had to give the reason.

Table 4.15: Reasons given if one has consulted the patient who exhibits an advanced stage of illness (N=92)

Statement	Yes		No		Total	
	Frequency	%	Frequency	%	N	%
Do patients consult clinic at advanced stage of illness?	69	75	23	25	92	100
Reasons given in "yes" answer	**Frequency**		**%**			
Patients come with complications.	24		34.8			
Patients consult traditional healers first because it is part of their culture.	8		11.6			
After traditional healers treatment has failed	8		11.6			
Witchcraft verification/confirmation	7		10.1			
Patients are delayed at traditional healers.	6		8.7			
The community comes to the clinic to prevent complications.	4		5.8			
Community believes that traditional healers can cure certain diseases (diarrhoea, TB, STD, HIV/AIDS, dehydration and psychiatric illness).	3		4.3			
They come to ask for a death certificate.	3		4.3			
They come for confirmation of a condition.	3		4.3			
The community trust and believe in sangomas.	2		3.0			
Financial constraints	1		1.5			
Total	**69**		**100**			

Table 4.15 shows that the majority 24 (34.8 %) of the respondents indicated that patients come to the clinic for consultation when an illness is already at an advanced stage or when complications are evident. Other patients (8 or 11.6 %) consult traditional healers before going to a clinic because they have been culturally conditioned to do so. Yet other patients (8 or 11.6 %) come to the clinic if they realise that the treatment which has been given by traditional healers has failed. The validity of these findings is confirmed by Mvuyo (1992:28), who noted that the community have faith in traditional healers and that they believe in the efficacy of their treatments. In spite of such trust, patients often arrive at the

clinic with terrible complications. The community's traditional culture and belief systems lead them to believe that traditional healers are men and women of power and that they are able to cure diseases.

QUESTION 15: WHAT TYPE OF HEALTH EDUCATION IS GIVEN TO PATIENTS BY TRADITIONAL HEALERS?

It is essential that members of the community be educated in how to prevent disease and promote health. This kind of education is called "health education". If traditional healers are going to take their place alongside community health nurses as providers of primary health care, they will have to accept that they have a role to play in educating the community in matters of health education – a function that is now largely performed by community health nurses. Question fifteen was an open-ended question and the responses were categorised into themes for the purpose of analysis. Seven themes were identified and these are reflected in table 4.16.

Table 4.16: Type of health education given by traditional healers (N = 46)

No	Themes	Frequency
1	Cleanliness/hygiene	9
2	Witchcraft	8
3	Not mixing traditional and clinic medicines	8
4	Healing practices	7
5	Diseases	7
6	Food	4
7	Cultural beliefs	3
	Total	**46**

The researcher categorised the types of health education given by traditional healers into themes. Seven (7) themes were identified and these are shown in table 4.16. Only 46 respondents answered this question. Nine respondents mentioned factors relating to cleanliness and hygiene. It is encouraging to note that traditional healers are indeed concerned with matters of cleanliness and hygiene because they are also perceived as using unhygienic methods and treatments. The following responses indicate what this concern with cleanliness and hygiene includes:

- Traditional healers asked their clients to bring new razor blades.
- Washing after treatment.

Blackett-Sliep (1989:44) has noted that the instruments used by traditional healers are not always hygienically used and that such practices can facilitate the transmission of disease. It is the responsibility of primary health care nurses to identify such potentially harmful practices and educate traditional healers about the consequences of unhygienic methods and practices. Eight of the respondents mentioned that traditional healers gave health education about witchcraft. Some of the responses indicated that a traditional healer had asserted that a member of the patient's family or a neighbour was suspected of witchcraft. Mvuyo (1992:36) indicated that the community believes strongly in witchcraft and that they believe that witchcraft causes various illnesses.

The respondents mentioned that traditional healers warned their clients not to mix traditional and clinic medicines. This is significant and an important aspect of health education which was mentioned by 8 (9.4 %) of the respondents. This kind of advice by traditional healers could impact favourably on integration of traditional and Western-style medicine because traditional medicine and Western medicine often contain the same substances. Patients who take both traditional medicine and Western medicine at the same time are liable to overdose themselves – and this may have serious consequences for their health. The following were among the comments made by the respondents:

- Traditional healers discourage their clients from mixing medications because this can delay or nullify the healing process.
- Traditional healers advise that the mixing of medicines may cause complications.

Seven respondents made the following comments about healing practices:

- Traditional healers advise patients to obtain treatment from a hospital.
- Traditional healers encourage continuity of care.
- Traditional healers give advice about the care of a wound.
- Traditional healers advise patients to return so that their cases can be reviewed.

Traditional healers expect their clients to continue with treatment at home – thereby encouraging them to participate in their own care. Although traditional healers prescribe their own treatment, they nevertheless encourage patients to visit hospitals for treatment where appropriate – and to return to the hospital for a follow-up review of their cases. This is a factor that could facilitate the integration of traditional healers into primary health care.

Seven respondents made observations which related to disease. It is well known that traditional healers are capable of successfully treating certain conditions. Respondents mentioned that traditional healers were often successful in treating:

- chronic diseases
- mental illnesses

If traditional healers are successful in healing chronic diseases and mental illnesses, their integration into the primary health care system will benefit all concerned. Pick (1996:17-231) and Mvuyo (1992:27) noted that traditional healers are effective in the treatment of chronic diseases such as hypertension. Bodibe (1988:87) also noted that both traditional healers and the majority of the mental health care team members agreed that they could work productively and with one another in the treatment of the mentally ill patients. This suggests that the formal integration of traditional healers into the primary health care system will benefit patients who suffer from these disorders.

Four respondents mentioned food as an important theme in health education. The following observations were made:

- Traditional healers advised patients not to eat certain foods.
- Traditional healers put some of their patients on a low salt diet.
- Traditional healers advised some of their patients to avoid sugar in their diets.

It should be noted that such practices will help to prevent hypertension and diabetes mellitus since a low salt diet and the avoidance of sugar are part of the regimen for treatment of such disorders. This is further evidence that traditional healers may profitably be integrated into the primary health care system because the treatments which they are using are already a part of Western medicine.

Setiloane (1988:43) notes that a pregnant woman is not supposed to eat certain foods and that older people will choose the correct food for them. Because food and diet profoundly affected the health of individuals and form part of the treatment schedule for many different diseases, it will benefit patients if intersectorial collaboration between traditional healers and Western medical personnel can be promoted.

Cultural beliefs were mentioned by three respondents who indicate that traditional healers educate their clients about:

- curses from the ancestors.
- traditional spiritual beliefs.

The above subcategories on health education indicate a difference between traditional and Western methods of health education. Since it is customary for clients first to consult traditional healers, it is the client who will benefit from the integration of traditional and Western health care traditions.

QUESTION 16: DO YOU FEEL THAT TRADITIONAL HEALERS SHOULD BE INTEGRATED INTO PRIMARY HEALTH CARE?

QUESTION 17: IF INTEGRATED, SHOULD A TRADITIONAL HEALER BE PROVIDED WITH FACILITIES?

QUESTION 18: IF YES, WHAT PROCEDURES OR ACTIVITIES SHOULD BE PERFORMED BY TRADITIONAL HEALERS IF THEY ARE INTEGRATED?

These questions identify the attitude of community health nurses and the procedures that they believe should be carried out by a traditional healer.

Table 4.17 Attitudes on the integration of traditional healers into primary health care (N = 94)

Question	Attitudes	Yes		No		Total	
		Frequency	%	Frequency	%	N	%
16	Do you feel that traditional healers should be integrated into primary health care?	78	83	16	17	94	100
17	If integrated, should a traditional healer be provided with facilities?	63	67	31	33	94	100

Table 4.17 shows that 78 (83 %) of the respondents indicated that they feel that traditional healers should be integrated into primary health care. The fact that the majority of respondents agree with the question suggests that integration will be viable. These responses demonstrate that those who are working in the community with traditional healers believe that integration is both possible and viable. Only a few, 16 (17 %) of the respondents disagreed and their attitude might be influenced by their cultural beliefs. A substantial percentage of respondents, 63 (67 %) emphasised that traditional healers should be provided with facilities where they could conduct their consultations.

If respondents had answered "yes" to question 18, they had to indicate which procedures they believe traditional healers should be allowed to perform. Table 4.18 lists the 24 activities/procedures which were indicated by the respondents who had answered "yes" to question 18. Because respondents could list more than one activity, the total number of activities/procedures comes to more than 96.

Table 4.18: Procedures traditional healers should perform

Procedures/Activities	Frequency	%
Traditional healers should engage in health education and make suggestions to the clients in their clinics.	21	21.9
Traditional healers need to be taught to use aseptic techniques (such as the use of gloves and new razor blades).	16	16.7
Traditional healer should be educated to refer patients who present with conditions which they cannot treat to clinics.	15	15.6
Traditional healers need to be able to screen patients.	11	11.05
Traditional healers need to be skilled in wound dressing.	7	7.2
Traditional healers need to be able to supervise treatments and prescribe medicines (especially for psychiatric patients, depression and diarrhoea).	6	6.3
Traditional healers need to be able to perform oral rehydration.	6	6.3
Traditional healers should participate in inservice education and hold meetings.	5	5.2
Traditional healers should be able to manage the distribution of drugs.	4	4.2
Traditional healers should be able to record vital data.	3	3.1
Traditional healers to teach their client to identify the signs and symptoms of their diseases – especially diseases or disorders such as TB, diabetes mellitus and diarrhoea.	2	2.08
Traditional healers should be able to diagnose other illnesses.	2	2.08
Traditional healers should be trained in the use of massage equipment.	2	2.08
Traditional healers should be able to provide their clients with psychological support.	2	2.08
Traditional healers should know when they need to visit clinics for advice.	2	2.08
Traditional healers should be skilled in taking a patient's history.	2	2.08
Traditional healers should be skilled in the art of counselling.	1	1.04
Traditional healers should be knowledgeable about environmental hygiene.	1	1.04
Traditional healers should be able to carry out spiritual examination.	1	1.04
Traditional healers should be able to administer enemas under supervision.	1	1.04
Traditional healers should check their clients regularly.	1	1.04
Traditional healers should perform their traditional examinations.	1	1.04
Traditional healers should be able to administer steam inhalations.	1	1.04
Traditional healers should be able to perform physical examinations.	1	1.04

Question 15 has already shown us that traditional healers are deficient in some aspects of health education. In view of this, it is interesting to note that 21 respondents (21.9 %) indicated that they believed that traditional healers should be engaged in health education. Of the total number of respondents, 16 (16.7 %) believed that traditional healers should be taught to use aseptic techniques and 15 respondents (15.6 %) believe that traditional healers should refer patients to clinics. The screening of patients was mentioned by 11 (11.5 %) of the respondents. Table 4.18 shows that various respondents believe that traditional healers should be able to dress wounds, supervise the taking of medicine,

perform oral rehydration and consult clinics. Shai-Mahoko (1997:137-138) recommends that traditional healers should be educated and empowered to participate in community health education programmes so that they will be able to act effectively to prevent or treat diarrhoea and vomiting. Shai-Mahoko also recommends that traditional healers be taught basic methods of sterilization such as boiling, flaming, the use of spirits and the basics of personal and environmental hygiene.

QUESTION 19: DO YOU THINK TRADITIONAL HEALERS ARE EFFECTIVE IN TREATING CERTAIN DISEASES?

QUESTION 20: IF YES, IDENTIFY THOSE DISEASES.

It should be noted that traditional healers are successful in treating certain diseases. Questions 19 and 20 will determine how effective traditional healers are in treating diseases and which diseases can be treated effectively by traditional healers.

Table 4.19 Treatment of certain diseases (N = 93)

Statement	Yes		No		Total	
	Frequency	%	Frequency	%	N =	%
Do you think traditional healers are effective in treating certain diseases?	54	58.1	39	41.9	93	100

Table 4.19 shows that fifty-four of respondents (58.1 %) indicated that traditional healers can treat certain diseases effectively, whereas thirty-nine (41.9 %) disagreed with this statement. According to Mahape (1995:51), the majority of respondents examined in her research (44 %) disagreed with a similar statement: a finding which is remarkably similar to the findings of this research. Mahape (1995:51) notes that traditional healers are ineffective in their treatments because their medicines are made from bizarre ingredients which are potentially dangerous. In Mahape's (1995:54) study only 15 percent of the respondents agreed with the statement that traditional healers are effective in treating certain diseases.

The fifty four (58.1%) respondents who indicated that traditional healers can treat certain diseases effectively identified the conditions which the traditional healers can treat as displayed in table 4.20.

Table 4.20: Diseases that traditional healers can treat effectively.

Diseases	Frequency	%
Mental/psychiatric illness	28	29.2
Digestive diseases (e.g. constipation, vomiting, *noga ya mathosa* and diarrhoea.	20	20.8
Sexually transmitted disease (gonorrhoea, AIDS/HIV infections)	14	14.6
Diabetic gangrene	10	10.4
Infertility	8	8.3
Skin conditions (sores, abscess and *sebabo* (rash))	7	7.3
Boswagadi (customary conditions)	6	6.3
Sefola (ulcer)	5	5.2
Migraine/headache	5	5.2
Sejoso (poisoning)	3	3.1
Respiratory infections, TB and influenza	3	3.1
Makgome (sexually transmitted diseases contacted from a widower/widow)	3	3.1
Epilepsy	3	3.1
Epistaxis	2	2.05
Hypertension	2	2.08
Asthma	1	1.04
Marasmus	1	1.04
Infections	1	1.04
Badimo (spirits)	1	1.04
Oedema	1	1.04
Love instillation	1	1.04
Unemployment	1	1.04
Dehydration	1	1.04

The data on all the diseases mentioned were reduced, integrated and modified so as to avoid duplication of facts. The results are displayed in table 4.20 above. The disorder which the largest number of respondents, 28 (29.2 %) identified as being amenable to effective treatment by traditional healers was psychiatric or mental illnesses. Twenty respondents (20.8 %) identified digestive disorders (including diarrhoea, vomiting and *noga ya mathosa* which is another name for diarrhoea and vomiting) as conditions which traditional healers can effectively treat. Fourteen respondents (14.6 %) indicated that traditional healers are effective in treating sexually transmitted diseases, while 10 respondents (10.4 %) mentioned that traditional healers are effective in treating diabetic gangrene. Blackett's (1989:95) research, records that 41.7 percent of the respondents

indicated that Western doctors and traditional healers (*inyanga*) can treat *iqondo* (a Zulu culture-specific sexually transmitted disease). Infertility and skin condition and diseases were also mentioned as being diseases that traditional healers can effectively treat. Each of the following diseases were mentioned by only one respondent (1.04 %) as being disorders which traditional healers can effectively treat: *Badimo*, oedema, unemployment (social need), dehydration and asthma. In the study by Mvuyo (1992:28), 41.5 percent of the respondents indicated that fits, impotence and *amafufunyane* may be cured by traditional healers. Mvuyo (1992:28) notes that *amafufunyane* refers to a kind of abnormal behaviour that is associated with falling down but is not caused by an epileptic fit. This list could help community health nurses to understand which diseases traditional healers are most skilled in treating and alleviating.

QUESTION 21: TRADITIONAL HEALERS SHOULD BE INTEGRATED IN THE FOLLOWING LEVELS OF PREVENTION:

- **PRIMARY PREVENTION**
- **SECONDARY PREVENTION**
- **TERTIARY PREVENTION**

QUESTION 22: SUPPORT THE ANSWER CHOSEN FROM QUESTION 21.

The two questions were combined and the respondents were asked to determine the level at which traditional healers might be most effective in the treatment and prevention of disease. Traditional healers and Western healers and nurses become involved at different levels in preventing illness and promoting health. Table 4.21 reveals the opinions of respondents about the levels at which traditional healers should or should not be integrated into primary health care – and the reasons for such opinions.

Table 4.21: Integration of traditional healers at levels of prevention

Level of Prevention	N =	Frequency	%	Reasons given
Primary	84	Yes		• Traditional healers should be educated about sterile procedures. • Traditional healers should be taught how to give health education so that diseases may be prevented. • Traditional healers should prevent disease by referring patients earlier.
		78	92.9	
		No		• Traditional healers make the condition of their clients worse. • Traditional healers do not observe the basics of hygienic practice. • Traditional healers cannot do anything to improve the condition of clients.
		6	7.1	
Total		84	100	
Level of Prevention	**N =**	**Frequency**	**%**	**Reasons given**
Secondary	40	Yes		• Traditional healers have a role to play in the continuity of health education. • Traditional healers can diagnose, treat, manage and refer patients. • Traditional healers should continue with health education so as to prevent further complications. • Traditional healers can treat the infections that accompany HIV/AIDS.
		17	42.5	
		No		• Traditional healers cannot successfully treat any conditions. • Traditional healers only worsen the condition of patients. • Traditional healers are not medically trained. • Traditional healers cause numerous deaths because they overdose their clients when treating them.
		23	57.5	
Total		40	100	
Level of prevention	**N =**	**Frequency**	**%**	**Reasons given**
Tertiary	42	Yes		• Traditional healers as well as Western medical practitioners can take part in the rehabilitation of patients. • Traditional healers can contribute to the continuity of health education. • Traditional healers should refer their patients for further rehabilitation.
		17	41.5	
		No		• Traditional healers cannot rehabilitate patients because they are more interested in making money. • Traditional healers should not be included in tertiary level.
		25	58.5	
Total		42	100	

The majority of the respondents, 78 (92.9 %) indicated that traditional healers should be integrated at a primary level of disease prevention by giving health

education to their clients and by referring them when necessary to hospitals and clinics. Of the 84 respondents who answered the question, 6 (7.1 %) indicated that traditional healers should not be integrated into primary disease prevention because they worsen the condition of their clients, because they are not really effective and because they are also unhygienic in their practices.

At the level of secondary prevention, 23 (57.5 %) of the 40 who answered the question were opposed to the integration of traditional healers. The reasons which they gave for this opinion were that:

- traditional healers worsen the condition of their patients.
- traditional healers are not medically trained.
- traditional healers cause many deaths.

The 17 respondents (42.5 %) who agreed with the statement indicated that traditional healers could provide continuity in health education, diagnosis, treatment, management and a referral of patients. They also believed that traditional healers can treat HIV/AIDS and provide continuous health education. The majority of nurses, 25 (58.5 %) who responded were opposed to integration of traditional healers at tertiary level because, in their opinion, traditional healers are unable to rehabilitate clients and are "moneymakers". The respondents, 14 (41.5 %) who opted for "yes" indicated that traditional healers *are* able to rehabilitate their clients and that they *are* able to refer them for further rehabilitation.

4.4 SECTION C: ATTITUDES OF COMMUNITY HEALTH NURSES

Community health nurses have different attitudes that may influence the integration of traditional healers into primary health care. This section is of vital importance because it determines the attitudes of community health nurses to integration. It deals with attitudes to consultation, the referral system and the formation of partnerships. Six statements were made to which respondents had

to respond.

STATEMENT 1: **PATIENTS SHOULD CONSULT TRADITIONAL HEALERS FOR THEIR ILL-HEALTH.**

STATEMENT 2: **PATIENTS SHOULD VISIT THE CLINIC BEFORE CONSULTING TRADITIONAL HEALERS.**

STATEMENT 3: **COMMUNITY HEALTH NURSES SHOULD ACCEPT A REFERRAL NOTE FROM TRADITIONAL HEALERS.**

STATEMENT 4: **COMMUNITY HEALTH NURSES SHOULD REFER A PATIENT TO A TRADITIONAL HEALER IF THE PATIENT REQUESTS.**

STATEMENT 5: **TRADITIONAL HEALERS SHOULD BE ENCOURAGED TO REFER PATIENTS TO CLINICS IMMEDIATELY AFTER CONSULTATION.**

STATEMENT 6: **TRADITIONAL HEALERS SHOULD BE A PART OF THE PRIMARY HEALTH CARE TEAM.**

These questions were all combined as they determine the attitudes of community health nurses. The responses to the questions are displayed in table 4.22. The words **agree**, **disagree** and **uncertain** were used to indicate the degree of agreement with the statement.

Table 4.22: Attitudes of community health nurses

Question	Statement	Agree		Disagree		Uncertain		Total	
		F	%	F	%	F	%	N =	%
1	Patients should consult traditional healers for their ill health.	24	25.5	38	40.4	32	34.1	94	100
2	Patients should visit the clinic before consulting traditional healer.	85	884	1	1.1	9	9.5	95	100
3	Community health nurses should refer patients to a traditional healer if a patient requests it.	50	52.6	25	26.3	20	21.1	95	100
4	Community health nurses should accept referral notes from traditional healers.	79	83.2	6	6.3	10	10.5	95	100
5	Traditional healers should be encouraged to refer patients to clinics immediately after consultation.	86	90.5	2	2.1	7	7.4	95	100
6	Traditional healers should form part of the primary health care system.	80	84.2	7	7.4	8	8.4	95	100

Of the 95 respondents, 86 (90.5 %) agreed that traditional healers should be encouraged to refer their patients to the clinics immediately after consultation. This substantial percentage indicates that integration is possible as long as all health providers are willing to cooperate. Eighty five respondents (88.4 %) agreed that patients should visit the clinics *before* consulting traditional healers. This shows that community health nurses are of the opinion that if patients consult the clinic before traditional healers, all conditions/diseases can be properly treated according to particular protocols. The majority, 79 (83.2 %) of the respondents agreed that community health nurses should accept referral notes from traditional healers. An acceptance of a referral note will facilitate continuity of care and prevent further complications.

Of the respondents, 80 (84.2 %) agreed with the statement "Traditional healers should form part of primary health care". It is community nurses who need to have a more positive attitude if they are to form part of the primary health care team because traditional healers are already available, accessible and acceptable to the community. While 38 respondents (40.4 %) disagreed with the statement "Patients should consult traditional healers for their ill-health", only 24

(25.5 %) agreed with the statement, and 32 (34.1 %) were unsure. This is an important finding: while some community health nurses emphatically agree that patients should be able to consult a traditional healer for their health problems, some disagree that patients should be given any freedom to choose the health services which they might prefer.

4.5 SECTION D: OPINIONS, BELIEFS, VIEWS AND IDEAS REGARDING INTEGRATION OF TRADITIONAL HEALERS INTO PRIMARY HEALTH CARE

In this section the respondents were given an opportunity to provide relevant information regarding their opinions, beliefs, views and ideas.

QUESTION 1.1: WHAT ARE YOUR OPINIONS?

The following themes were identified from the responses received to the question which solicited the opinions of community health nurses about integration.

Table 4.23: The opinions of respondents regarding integration (N = 58)

No.	Themes	Frequency	%
1	Integration/coordination of traditional healers and clinic staff	22	37.9
2	Training traditional healers	19	32.7
3	Health education	7	12.1
4	Negative towards integration	7	12.1
5	Cultural aspects	3	5.2
Total		**58**	**100**

From the themes shown in table 4.23, the following subcategories could be identified:

Table 4.24: Themes and subcategories on opinions for integration

No.	Themes	Subcategories
1	Integration/coordination of traditional healers	1.1 Traditional healers should be integrated into primary health care. 1.2 Traditional healers and community health nurses should work as a team. 1.3 Community health nurses and traditional healers should share ideas. 1.4 Patients should not be discouraged to consult traditional healers. 1.5 The practice of traditional healers should be recognised. 1.6 Traditional healers should be respected at all the times. 1.7 Traditional healers should assist health care workers. 1.8 There should be good communication between traditional healers and community health nurses.
2.	Training traditional healers	2.1 Traditional healers should be trained about health issues. 2.2 Traditional healers should be evaluated on set criteria. 2.3 Traditional healers should be given in-service training. 2.4 Traditional healers should be given the skills to diagnose conditions that they cannot treat but which can be treated medically by health professionals. 2.5 Traditional healers should perform sterile procedures. 2.6 Traditional healers should work according to set standards.
3.	Cultural aspects	3.1 Traditional healers meet the spiritual needs of those who believe in them. 3.2 Traditional healers can cure certain diseases.
4.	Health education	4.1 Traditional healers should give health education to their clients. 4.2 Traditional healers can educate the community about the causes of disease.
5.	Negative towards integration.	5.1 Traditional healers should not be integrated into primary health care. 5.2 Traditional healers cannot reason. 5.3 Patients should first consult the clinic about their health problems.

Of the 58 respondents, 22 (37.9 %) indicated that integration could become a reality if the two services worked as a team and shared ideas. Respect for one another and good communication would form the basis for integration. Some of the responses which illustrated these points were the following:

- Traditional healers should be integrated into primary health care.
- Patients should not be discouraged from consulting traditional healers.

Although Hopa, Simbayi, and Du Toit (1998:10), Mahape (1995:74) and Troskie (1997(b):35-36) support collaboration with traditional healers in primary health care, Mvuyo (1992:39) believes that health authorities should seriously consider integrating traditional healers into a future national health care system. If more health care providers were to support collaboration, integration would also be encouraged in primary health care.

Of the respondents, 19 (32.7 %) were of the opinion that traditional healers should be trained. Training is an important issue because healers need to be trained in basic health matters and skills. At the conclusion of such training, traditional healers would be evaluated according to certain standards such as the maintenance of surgical cleanliness. Traditional healers would also be provided with ongoing inservice education that would enhance their diagnostic skills and competence to treat patients. Green (1988:1129) is of the opinion that training workshops which will develop collaborative health care skills should be designed for traditional healers. Hopa et al (1998:13) believe that if integration is to be successful, the principle of *formal cooperation* should be adopted as the basis for integrating the two health systems.

Health education is a component of primary health care and should be provided on a continual basis. Seven (12.1 %) respondents indicated that health education could be used as a strategy to promote successful integration. If traditional healers could provide their patients with efficient health education (especially about the causes of disease), the incidence rate of various diseases could be brought down.

According to WHO (1981:149), traditional birth attendants advise pregnant women about diet preparation and preservation after the completion of their training. This indicates that if traditional healers could be trained to provide efficient health education, the incidence of conditions such as malnutrition and

kwashiorkor could be minimized. Seven (12.1 %) respondents indicated that traditional healers should not be integrated into primary health care because they "cannot reason". Such response might be attributable to the influence of Christian attitudes to indigenous medicine or merely to a negative attitude towards integration.

QUESTION 1.2: WHAT ARE THE BELIEFS REGARDING INTEGRATION OF TRADITIONAL HEALERS INTO PRIMARY HEALTH CARE?

The beliefs of the respondents about traditional healing practice obviously play a major role in influencing their beliefs to the integration of traditional healers into primary care. Those who believe that traditional healers can perform beneficial work will naturally tend to view integration positively, but those who believe the opposite will tend to view integration negatively.

Table 4.25: Respondents beliefs regarding integration (N = 96)

No.	Beliefs	Frequency	%	Reasons given
1.	Respondents who believe in traditional healers	57	59.4	1.1 The community should integrate traditional healers into primary health care because their culture is acceptable. 1.2 Traditional healers should be integrated because this will mean that patients will be seen earlier in clinics and hospitals – thus preventing avoidable complications. 1.3 Common goals can be reached. 1.4 Traditional healers and community health nurses will learn from each other. 1.5 Greater numbers of people in the community will be reached. 1.6 Traditional healers and community health nurses should work as a team. 1.7 Traditional healers should be integrated in order to prevent HIV/AIDS infections. 1.8 The community's beliefs should be respected.
2.	Respondents who do not believe in traditional healers	20	20.8	2.1 Traditional healers will have difficulty in referring patients. 2.2 Traditional healers are the cause of increased Mortality rates 2.3 Traditional healers tend to attribute all diseases to witchcraft.
3.	Respondents who did not provide the required information	19	19.8	
Total		**96**	**100**	

Table 4.25 shows that a substantial number of the respondents, 57 (59.4 %) believe in traditional healers and believe that traditional healers are able to successfully treat certain conditions. This data corresponds with the responses to question 19 which showed that 54 (58.1 %) agreed that traditional healers could treat certain diseases effectively. The respondents who believe in traditional healers indicated that traditional healers should be integrated into primary health care. The reasons why they believe in traditional healers are tabulated in table 4.25. A few respondents 20 (20.8 %) do not believe in traditional healers even though all the community health nurses who participated in the study were of African origin (as may be seen from the response to question 4 in Section A). It is also notable that 85.1 percent mentioned that they belonged to a Christian church denomination. The higher rate of Christian affiliation among the respondents might have influenced the negative responses to traditional healers. Van Niekerk, cited by Troskie 1997(a), has noted that many African people believe that being a Christian is not incongruent with believing in the efficacy of traditional healers. Of the 96 respondents, only 19 (19.8 %) did not provide the required information about their beliefs. These respondents might have deliberately omitted the question or else they might have forgotten to complete the questionnaire.

QUESTION 1.3: WHAT ARE THE VIEWS OF RESPONDENTS ABOUT THE INTEGRATION OF TRADITIONAL HEALERS?

Because respondents could give more than one response, the frequency and percentage do not add up to 96 (100%).

The themes in table 4.26 were identified from the opinions which respondents gave about their views on the integration of traditional healers into primary health care.

Table 4.26: Themes extracted from views of community health nurses about integration (N = 79)

Themes	Frequency	%
Collaboration with traditional healers	38	48
Training traditional healers	15	19
Referral of clients by traditional healers	11	13.9
Reasons for consulting traditional healers	10	12.7
Traditional healers should give health education	5	6.3

Of the respondents, 27 did not view integration as a possibility. One respondent indicated that research is necessary to determine how traditional healers manage their clients.

Within each of these themes, different subcategories could be identified. These are displayed in table 4.27.

Table 4.27 Themes and subcategories identified with regard to views about the integration of traditional healers

Themes		Subcategories	
1	Training traditional healers	1.1	Health education
		1.2	Inservice education about health issues
		1.3	Training in pharmacology
2	Collaboration	2.1	Traditional healer forms part of the system.
		2.2	Improve relationships of trust
		2.3	Recognition of and respect for traditional healers
		2.4	Chance to express views
3.	Referral of clients by traditional healers	3.1	Prevents diseases and complications
		3.2	Prevents death
4.	Reasons for consulting traditional healers	4.1	Patients have confidence in traditional healers
		4.2	Clinics not available
		4.3	Methods of treatment
5.	Traditional healers should give health education.	5.1	Can reduce sexually transmitted diseases.
		5.2	Medicine of traditional healer are effective.
		5.3	To prevent diseases
		5.4	To bring own razor blades

Subcategories deduced from the above themes were identified and displayed. Table 4.27 shows that if training can be instituted, health education, inservice

education and training in pharmacology will be enhanced. If a proper system of collaboration is introduced, traditional healers will form part of a network of trust and recognition and respect will be ensured. Troskie (1997(b):35) is of the opinion that collaboration with traditional healers in primary health care services could benefit the community, and Mafalo (1997:12) believes that all healers and some nurses and consumers wish to see a proper system of collaboration between the Western medical health care system and the indigenous healing system. Dauskardt (1990:335) notes that Chang introduced Primary Health Care Training for Indigenous Healers (PRHETIH) in 1979 in a context of government support for traditional healers. If proper collaborative efforts are initiated, clients will be able to express their own opinions and pursue their own choices. The referral of clients by traditional healers will prevent unnecessary diseases, complications and even deaths. Table 4.27 also shows why people consult traditional healers. Amongst such reasons, the unavailability of a clinic was mention as a problem in certain areas. Mvuyo (1992:28) confirms this statement and notes that clients consult traditional healers because Western-style medical services are not available in some areas. Because traditional healers are health care providers, they are in a position to provide health education and so prevent diseases such as STDs. According to Salus (1994:7), traditional healers should be included in primary health care because they are effective in preventing the spread of HIV/AIDS by educating their clients within the communities which they serve.

QUESTION 14: WHAT ARE YOUR IDEAS ABOUT THE INTEGRATION OF TRADITIONAL HEALERS INTO PRIMARY HEALTH CARE?

This subsection determines the ideas of respondents about integration of traditional healers into primary health care. The following themes were identified from the question on ideas for integrating traditional healers into primary health care.

Table 4.28: Themes identified on ideas for integration

No.	Themes	Frequencies %
1	Educating traditional healers	29
2	Improving health	22
3	Change in attitude	15
4	Referral	5
5	Availability	3
6	No integration	2
Total		**76**

From the themes as displayed in table 4.28 the following subcatogories could be identified as displayed in table 4.29.

Table 4.29: Themes and subcategories on ideas for integration (N = 76)

No.	Themes	Sub-categories
1.	Educating traditional healers	1.1 Training 1.2 Certificates 1.3 Standards 1.4 Protocols
2.	Referral	2.1 Referral system 2.2 Diseases to be referred
3.	Change in attitude	3.1 Transparency 3.2 Acceptance of traditional healers 3.3 Respect for traditional healers
4.	Improving health	4.1 Primary health care 4.2 Hygiene 4.3 Supervision of medication
5.	Availability	5.1 More accessible care 5.2 Traditional healers should be more accessible.

Themes and subcategories are displayed in table 4.29. Educating traditional healers will improve the provision of services. Protocols and standards were identified as they will enhance effective training. Respondents indicated that traditional healers should be certificated after completion of training. Bodibe (1988:60) indicates that 85 (85 %) of the respondents in his study underwent training. He mentioned remuneration but did not mention any protocols or standards. The following subcategories were deduced from referral:

- referral system
- diseases to be referred

Respondents emphasised that there should be a referral system which will enable traditional healers and community health nurses to refer to each other those conditions which the traditional healers or community nurses are especially effective in treating. The following steps need to be taken to change the attitudes of community health nurses:

- Transparency should become a norm in the relations between traditional and Western medical practitioners.
- Community health nurses need to learn to accept and respect traditional healers.

Shai-Mahoko (1997:137) also believes that clinic nurses need to change their attitudes. Respondents indicated that primary health care, the implementation of hygienic procedures and the proper supervision of medicine will improve health in the community. Respondents expressed the opinion that if integration is successful, health care will become more accessible to all as the services of traditional healers are integrated with those provided by community clinics and hospitals. Dennil et al (1999:6) indicated that primary health care should be available if the particular health needs of each community are to be met. Health care services should also be geographically, financially and functionally accessible to people in rural and under privileged areas. This recommendation is supported by De Haan (1996:11) who cites WHO sources. Proper health care can only be available and accessible in South Africa if traditional healers are integrated into the provision of primary health care.

4.6 SECTION E: THE ROLE OF TRADITIONAL HEALERS IN THE COMMUNITY

The information gathered in this section is important because it will guide the researcher to comprehend the roles of traditional healers in the community. The integration of traditional healers into primary health care will be influenced by the attitude of the health care practitioners.

Eight statements about the role of traditional healers are displayed in table 4.31. The respondents had to indicate whether they believed the statements to be true or false.

STATEMENT 1: **THE TRADITIONAL HEALER IS A PERSON WHO IS RESPECTED AND RECOGNISED BY THE COMMUNITY.**

STATEMENT 2: **TRADITIONAL HEALERS PROVIDE CARE TO THE COMMUNITY.**

STATEMENT 3: **TRADITIONAL HEALERS ACT AS LEADERS IN THE COMMUNITY.**

STATEMENT 4: **TRADITIONAL HEALERS SHOULD PARTICIPATE IN HEALTH EDUCATION PROGRAMMES.**

STATEMENT 5: **TRADITIONAL HEALERS TREAT CERTAIN PHYSICAL AND MENTAL DISEASES EFFECTIVELY.**

STATEMENT 6: **TRADITIONAL HEALERS ARE ACCEPTABLE, ACCESSIBLE AND AVAILABLE TO THE COMMUNITY.**

STATEMENT 7: **TRADITIONAL HEALERS ARE MORE INVOLVED IN COMMUNITY CARE.**

STATEMENT 8: **TRADITIONAL HEALERS CAUSE DISRUPTION IN FAMILIES.**

The roles of traditional healers are displayed in table 4.30 below. As it will be noticed in the table the traditional healers have an important role to play.

Table 4.30: The roles of traditional healers in the community (N = 91-95)

State-ment	Roles of traditional Healers	True		False		Total	
		Frequency	%	Frequency	%	Frequency	%
1	Traditional healer is a person who is respected by the community.	83	87.4	12	12.6	95	100
2	Traditional healers provide care to the community .	62	67.4	30	32.6	92	100
3	Traditional healers act as leaders in the community.	53	55.8	42	44.2	95	100
4	Traditional healers should participate in health education programmes.	88	93.6	6	6.4	94	100
5	Traditional healers treat certain physical and mental diseases effectively.	59	64.8	32	35.2	91	100
6	Traditional healers are acceptable, accessible and available for continuity of care.	68	73.1	25	26.9	93	100
7	Traditional healers are more involved in the community	55	59.8	37	40.2	92	100
8	Traditional healers cause disruption in families	68	72.3	26	27.7	94	100

The majority of the respondents (93.6 %) emphasised that traditional healers should participate in health education programmes. According to 87.4 percent of the respondents, the traditional healer is a person who is respected by the community. If a person is respected in the community, this is usually an indication that, that person does some kind of special work or plays a particular role which benefits the community. Of the respondents 68(73.1%) agreed that traditional healers are acceptable, accessible and available for continuity of care.This is one of the reasons community members visit traditional healers.Respectively 62(67.4%) and 59(64.8%) indicated that traditional healers provide care and treat certain diseases effectively. This is a slightly higher percentage than displayed in table 4.25 where 57(59.4%) believed that traditional healers could treat certain diseases effectively. At the same time an almost equal percentage 55 (59.8%) agreed that traditional healers are more involved in community care. Of the 96 respondents, 72.3 percent indicated that traditional healers cause disruption in families because certain healers attribute disease to witchcraft and blame family members for practising witchcraft. Table 4.30 shows

that the lowest percentage of respondents (55.8%) indicated that traditional healers act as leaders in the community.The leadership role of traditional healers in the community influences their acceptability to the community.

4.7 SECTION F: CONSTRAINTS THAT HINDER INTEGRATION

In this section, responses to four statements (see table 4.32 below) determine what the respondents see as the constraints which hinder integration.

QUESTION 1: **LACK OF RESPECT AND TRUST BETWEEN TRADITIONAL HEALERS AND COMMUNITY HEALTH NURSES WILL HAMPER INTEGRATION.**

QUESTION 2: **TRADITIONAL HEALERS LACK STANDARDS AND CONTROLS IN THEIR PRACTICE.**

QUESTION 3: **TRADITIONAL HEALERS ARE EFFECTIVE IN PATIENT CARE.**

QUESTION 4: **POOR COMMUNICATION BETWEEN TRADITIONAL HEALERS AND COMMUNITY HEALTH NURSES WILL HAMPER INTEGRATION.**

Several problems may prevent integration of traditional healers in primary health care.

Table 4.31: Constraints which hinder integration (N = 96)

No	Statement	Yes	No	Total
		%	%	%
1	Lack of respect and trust between traditional healers and community health nurses will hamper integration.	95.7	4.3	100
2	Traditional healers lack standards and controls in their practice.	94.6	5.4	100
3	Traditional healers are effective in patient care.	94.6	5.4	100
4	Poor communication between traditional healers and community health nurses will hamper integration.	98.9	1.1	100

The respondents were required to respond to the statements by marking either "Yes" or "No". A substantial number of respondents (98.9 %) indicated that they perceived the lack of communication between traditional healers and community

health nurses to be a major constraint. It is incumbent upon both parties to communicate properly about the effectiveness of traditional healers in patient care. The lack of respect and trust between traditional healers and community health nurses was seen by 95.7 percent of the respondents to be a constraint to integration. Although (94.6%) percent of the respondents indicated that traditional healers lack standards and controls in their practice, the same percentage of respondents support the statement that traditional healers are effective in patient care. It is therefore obvious that traditional healers need to be empowered with health information so that they can provide a better standard of culturally effective care.The third statement was put in the positive , so it is not clear how effective care by traditional healers can be a constraint . It could perhaps be that western type healers see it as a threat to modern practice. It may also be that respondents did not note the positive way in which the statement was made. This could indicate a limitation in the statement.

QUESTION 5: IDENTIFY PROBLEMS THAT MAY PREVENT THE INTEGRATION OF TRADITIONAL HEALERS INTO PRIMARY HEALTH CARE.

This was an open-ended question: respondents were asked to list problems that could prevent integration. Respondents were allowed to list more than one problem that might be a constraint to integration.

Table 4.32: Categories or themes of problems that might be constraints

Question	Themes	Frequency
1	Differences in healing practices	59
2	Attitude of nurses or traditional healers	54
3	Cultural differences between traditional healers and community health nurses	19
4	Control of traditional healer's practice	19
5	Lack of respect	14
6	Facilities of traditional healer	5
7	Other	4
Total		**164**

The problems listed by the respondents were categorised into themes. Seven main themes were identified and these are displayed in table 4.32. Differences in healing practices was the theme most frequently listed by 59 of the respondents. This is shown in table 4.33.

The second most common theme indicated by fifty-four respondents was the attitude of nurses and traditional healers.

Cultural differences were indicated by nineteen of the respondents as a problem that might be a constraint in integrating traditional healers in primary health care. Control of the practice of traditional healers was also indicated by nineteen of the respondents as a possible constraint.

Under the heading **Other**, the following four problems were highlighted:

- Nurses have a fear of the unknown when it comes to integration.
- Traditional healers are ignorant.
- Lack of team spirit by both traditional healers and community nurses
- The actions and behaviour of nurses are controlled by the legal requirements of their practice.

From the themes displayed in table 4.32 the researcher identified the subcategories which are tabulated in table 4.33.

Table 4.33: Themes and subcategories on problems as constraints which hinder integration (N = 74)

Themes	Subcategories
1. Difference in healing practice	1.1 Methods of consultation 1.2 Death causation 1.3 Misconceptions on disease 1.4 Confidentiality 1.5 Financial costs/payments 1.6 Competition 1.7 Privacy 1.8 Unhygienic 1.9 Witchcraft
2. Attitude of nurses or traditional healers	2.1 Superstitions 2.2 Language 2.3 Cultural difference 2.4 Imposition
3. Control of traditional healer's practice	3.1 Standards 3.2 Scope of practice 3.3 Training
4. Facilities of traditional healers	4.1 Examination room 4.2 Poor reputation
5. Lack of respect from both traditional healers and community health nurses	5.1 Lack of recognition. 5.2 Lack of confidence

Troskie (1997(b):25) confirms the above statements in her study on the role of the nurse in collaboration with traditional healers in primary health care clinics. This is an indication that traditional healers are negligent and that they lack team spirit. The respondents indicated that traditional healers utilise different healing practices and that their methods of examination are especially different. (See table 4.11.) Respondents demonstrated different attitudes towards traditional healers. They mentioned that traditional healers are superstitious in their practice and that they sometime use difficult or obscure language during their examinations. The respondents further indicate that traditional healers should be controlled through training and by the setting of standards for practice.

4.8 SECTION G: WAYS OF ASSISTING WITH THE INTEGRATION OF TRADITIONAL HEALERS IN PRIMARY HEALTH CARE

This data will guide the community health nurses to facilitate the integration of traditional healers into primary health care.

QUESTION 1: **TRADITIONAL HEALERS SHOULD CONFORM TO CERTAIN STANDARDS WITHIN THE FORMAL SECTOR.**

QUESTION 2: **SUPPORT YOUR STATEMENT IF THE ANSWER TO ABOVE IS "NO".**

These questions were asked to determine whether traditional healers conform to certain standards when they consult their clients.

Table 4.34: Traditional healers should conform to standards (N = 92)

Statement	Yes		No		Total
	Frequency	%	Frequency	%	
Traditional healers should conform to certain standards within the formal sector.	89	96.7	3	3.3	100

Table 4.34 shows that the majority of the respondents (96.7 %) indicated that traditional healers should conform to certain standards within the formal sectors. Traditional healers should conform and use the policy and standards of existing health services in order to eliminate threats amongst health care providers. Mahape (1995:82) is of the opinion that formal policy guidelines should be provided to structure the practice of traditional healing. Good communication and respect will facilitate the introduction of standards and conformity to such standards. Only 3 (3.3 %) of the respondents answered "no" to the question. The reason given by those who answered "no" was that traditional healers cause clients to be more confused.

QUESTION 3: TRADITIONAL HEALERS SHOULD BE PROPERLY SELECTED ACCORDING TO SET STANDARDS.

QUESTION 4: HOW ARE THEY SUPPOSED TO BE SELECTED?

These questions address the problem of how traditional healers should be selected if they are to be integrated into primary health care.

Table 4.35: Selection of traditional healers (N = 88)

Statement	Yes		No		Total		How should traditional healers be selected?
	Frequency	%	Frequency	%	N	%	
Traditional healers should be properly selected for integration according to set standards.	67	76.1	21	23.9	88	100	Traditional healers should be selected according to: • Training level • Education • Certification • Skills • Capability • Interests • Speciality • Availability • Age • Residence • Experience • Culture There should be an assessment of traditional healers before integration takes place. Traditional healers should be able to communicate their views and opinions before integration takes place. Traditional healers should agree to attend in-service education before integration takes place. The traditional healers should be integrated on the basis of their reputation as ethical practitioners. Traditional healers should be selected according to "ubuntu".

Table 4.35 shows the responses to questions 3 and 4, and the methods of selection suggested are listed in the right-hand column.

The majority of respondents (76.1%) indicated that traditional healers should be

properly selected for integration and that they should be selected according to certain set (predetermined) standards, as indicated in table 4.35

It will be interesting if traditional healers are selected according to the criteria as mentioned in table 4.35. Training and education of traditional healers will enable the traditional healers to be capable specialists who will utilise the skills which they acquire in their practice.

QUESTION 5: TRADITIONAL HEALERS SHOULD BE LEGALISED.

QUESTION 6: SUPPORT THE STATEMENT IF YOUR ANSWER IS "YES".

These questions provide guidelines for legalising the practice of traditional healers before integration into primary health care can become a reality. Table 4.36 indicates that the majority 75(82.4%) of the respondents agreed that the practice of traditional healers should be legalised before integration.

Table 4.36 Legalising the practice of traditional healers (N = 91)

Statements	Yes		No		Total		Who should legalise traditional healers?
	Frequency	%	Frequency	%	N	%	
Traditional healers should be legalised.	75	82.4	16	17.6	91	100	• Government • Traditional healers association (dingaka) • People should vote. • Local authority • Medical/Dental (i.e. bodies such as the SAMDC) • The South African Nursing Council • A multi-disciplinary Team • Health security • The community • Courts of law • Social services

Only the respondents who answered "yes" to the question as to whether the

practice of traditional healers should be legalised were required to respond to question 6 about who should legalise the practice. Each respondent provided more than one body/organisation that should legalise the practice of traditional healers.

The *Dingaka* Association was mentioned by many respondents because many traditional healers undergo their training with the *Dingaka* Association. The *Dingaka* Association lays down rules about how traditional healers should practise. The association has its headquarters at Hammanskraal–Bosplaas and it is here that traditional healers hold their annual conferences to discuss their practice.

Other suggestions made by respondents were:

- The South African Nursing Council
- Government
- Community
- The local authority
- A multi-disciplinary team
- Health security
- Court of law
- Social services

Certifying bodies will be able to identify properly skilled and qualified healers to practise in the community and this will eliminate uncertainties.

Mahape (1995:81) indicated that the Minister of Health announced that traditional healers should be legally recognised as health care practitioners and that they should be received into the mainstream of the South African health care system.

QUESTION 7: **TRADITIONAL HEALERS SHOULD UNDERGO SOME FORM OF RECOGNISED TRAINING SO AS TO ENSURE PATIENT SAFETY.**

QUESTION 8: **CONSULTING ROOMS SHOULD BE CREATED IN CLINICS WHERE COMMUNITY HEALTH NURSES CAN WORK JOINTLY WITH TRADITIONAL HEALERS.**

QUESTION 9: **A RECOGNISED REFERRAL SYSTEM BETWEEN TRADITIONAL HEALERS AND COMMUNITY HEALTH NURSES SHOULD BE CREATED.**

QUESTION 10: **TRADITIONAL HEALERS SHOULD PARTICIPATE IN THE HEALTH EDUCATION PROGRAMME.**

These questions were combined because they determine the ways of integrating traditional healers in primary health care.

Table 4.37: Ways of assisting the integration of traditional healers into primary health care (N = 91-93)

Question	Statements	Yes		No		Total	
		Frequency	%	Frequency	%	Frequency	%
7	Traditional healers should undergo some form of recognised training so as to ensure patient safety.	91	97.8	2	2.2	93	100
8	Consulting rooms for traditional healers should be created in clinics where community health nurses can work jointly with traditional healers.	56	60.9	36	39.1	92	100
9	A recognised referral system between traditional healers and community health nurses should be created.	83	91.2	8	8.8	91	100
10	Traditional healers should participate in health education programmes.	91	97.8	2	2.2	93	100

Some form of recognised and certified training and participation in health education programmes by traditional healers is important for successful integration. Table 4.37 shows the higher rate of "yes" responses to questions 7

and 10: these responses represented 97.8 percent of the total number of responses. WHO (1981:32) is supportive of the idea that traditional healers should receive some form of certified and accredited training because it was WHO that pioneered the idea of accredited training for traditional healers in the interests of ensuring the safety of patients. Traditional birth attendants were trained in proper mother and child care and were also trained to provide health education for their clients. The success of this system suggests that if traditional healers are properly trained, they will be able to provide efficient for their patients.

Of the 91 respondents who responded, 91.2 percent indicated that an officially recognised referral system between traditional healers and community health nurses should be created because both consult patients and because patients should have the right to choose whom they wish to consult.

A fewer respondents (60.9 %) than those who supported questions 7 and 10 supported the idea of having a special consulting room where traditional healers and community health nurses might work jointly with patients. It is interesting to note that the creation of a special consulting room for joint consultation was supported by the clinic open jointly by traditional healers and medical doctors in Mpumalanga Province to improve the provision of comprehensive health care for their clients(Maelane 1999 September:Discussion).

QUESTION 11: IS THERE ANYTHING ELSE YOU WOULD LIKE TO COMMENT ON OR SAY ABOUT WAYS IN WHICH TRADITIONAL HEALERS CAN BE ASSISTED TOWARDS INTEGRATION?

The respondents were given an opportunity to elaborate more fully on ways in which they believed that traditional healers might be assisted with integration into primary health care. The question was deliberately left open so as to allow free discussion of ways in which integration might be facilitated. The responses

to question 11 were categorised and the following themes, shown in table 4.38, were identified.

Table 4.38: Themes on how to assist with integration (N = 86)

Themes	Frequency	%
Integration/collaboration	41	47.7
Educating/training traditional healers	29	33.7
Communication/respect	7	8.1
Fees and facilities	4	4.7
Standards	3	3.5
Other	2	2.3
Total	**86**	**100**

The ways in which traditional healers can be assisted towards integration as suggested by the respondents included collaboration, education, communication, providing facilities and setting standards.

These themes which are derived from responses and which are indicated in table 4.38 are very similar to those which were derived from the questions in section G (i.e. question 7 on training, questions 1 and 3 on standards and question 8 on consulting rooms). This might well be an indication of how important respondents view these factors if effective integration is to be achieved.

The above information is similar to section B (question 17 and 18), where the respondents indicated that traditional healers should be integrated into primary health care and should participate in health education programmes. This is also an indication that facilities such as free condoms and gloves for traditional healers are needed if the spread of disease caused by unhygienic practices is to be eliminated. Thailand is one country which has trained traditional birth attendants to educate clients about family planning. At the end of this course in Thailand, participant traditional birth attendants were provided with all the

supplies they needed to engage in proper practice. The traditional birth attendants who attended this course were expected to provide contraceptives to women who had already received an initial supply of contraceptives (WHO 1991:189).

If traditional healers are properly trained, they will be able to provide effective contraceptive and other care to their clients. Both traditional healers and community health nurses need to respect one another. The government should see to it that all traditional healers receive an appropriately designed and medically and culturally relevant education which will also provide them with appropriate guidelines and standards for their practice. Fees should be negotiated because fees can influence the provision of primary health care and even the method of payment.

4.9 SUMMARY

In this chapter the data obtained in all the sections were analysed. Graphs, percentages, frequencies and tables were used in section A to clarify data. The community health nurses demonstrated a positive attitude towards the integration of traditional healers into primary health care (See tables 4.7, 4.15, 4.17, 4.18, 4.19, 4.22, 4.23, 4.24, 4.26, 4.27, 4.34, 4.35, 4.36, 4.37, 4.38.) Various limitations were recognised and these will be discussed in chapter 5. Recommendations and conclusions will also be discussed in chapter 5.

CHAPTER 5

REVIEW OF FINDINGS, IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter focuses on reviewing the study and emphasises the limitations of the study and relevant and specific findings. The implications of specific findings and conclusions are discussed and various recommendations are made.

Throughout this study specific objectives were to:

- identify the attitude of community health nurses towards the integration of traditional healers into primary health care.

- identify and describe the role of traditional healers in the community.

- identify the constraints which hinder the integration of traditional healers into primary health care.

- determine ways and means of facilitating the integration of traditional healers into the primary health care system.

The following discussion will be structured according to the findings and the questionnaire will be used as a guide. This will be followed by a discussion in which the research objectives will be used as a guide. The findings will be compared with the literature reviewed. The conclusions will be stated , various recommendations will be made, the implications

of these conclusions and recommendations will be reviewed .

5.2 DISCUSSIONS OF FINDINGS

5.2.1 Response rate

The community health nurses who were used as a sample participated willingly in the study. Ninety-six (96 %) respondents completed the questionnaire in the three districts (Odi, Brits and Moretele).

5.2.2 Demographic factors relating to the interviewees

There was a disproportion in the ratio of female to male community health nurses who participated in the study. Female respondents 88 (91.7 %) were in the majority and only 8 (8.3 %) male respondents participated. These figures are almost exactly congruent with the South African Nursing Council's statistics which reveal that proportionately more females than males are registered as professional nurses (SANC 1998.12.31 (stats)).

The ages of respondents ranged between 20-61 years and were grouped into the two categories of < 41 years and > 41 years. The mode of the population age was category > 41 years at fifty one percent. It is evident that the majority of the respondents who participated in the study were older than 40 years. Their ages and their experience enabled them to provide ideas, opinions, beliefs and views about the integration of traditional healers into primary health care. An individual brings to a situation a set of values and beliefs and is concerned with learning new role behaviours (Oermann 1997:9). This, according to Oermann, is a characteristic of adult socialization and it is a characteristic that might well assist the nurse to be positive in her approach towards integration.

Religious beliefs may be defined as a person's orientation towards life as this is revealed in his/her thoughts, feelings and actions (Pera & van Tonder 1996:213). It is therefore clear that religion plays an important role in how nurses view the methods of examination which are used by traditional healers. It is also probable that the Westernised training which nurses have undergone affects how they view the methods used by traditional healers, which are deeply rooted in pre-Western African culture (Pera & van Tonder 1996:241).

Although the majority of the respondents 65 (68.4 %) were married, no meaningful link could be established between their marital status and their attitudes to integration. There was no statistically meaningful relationship between marital status and the attitude of respondents to integration because married, single, divorced and widowed respondents had a positive attitude towards integration of traditional healers in primary health care (see table 4.17). The overwhelming majority of respondents, 78 (83 %) answered "yes" to the statement about integration.

The ethnic group to which respondents belonged influenced the attitude of respondents to the provision of primary health care. It is obvious that different ethnic groups have their own folk health beliefs and practices. One should appreciate that sensitivity, respect and recognition need to be preserved with regard to ethnic differences. There is a majority of Tswana community health nurses, 65 (67.7 %) who are providing primary health care in the Odi region (Odi, Brits and Moretele districts) in the North West Province. This indicates that the nurses in the Odi region (Odi, Moretela and Brits) understand their patients better as they belong to the same culture as their clients. All respondents were also South African citizens. According to Searle and Pera (1995:72), the South African Nursing Council keeps registers and rolls to ensure the legality of nursing practice among all nurses in South Africa. All the respondents in Odi region (Odi,

Brits and Moretele districts) are South Africans and they all practise legally in their communities and their modes of practice are dictated by the statutory requirements of the South African Nursing Council.

It could not be established whether there was a meaningful link between a specific area or locality and the attitude of respondents to integration because nurses move freely between towns, villages and townships because they are allocated according to the particular needs of specific clinics. It was found that attitudes were uniform in towns, villages and townships.

Most of the respondents have 0-2 children, have passed standard 7-10 and are qualified as general nurses, midwives and community health nurses. The small number of children that nurses have might be attributable to the demands which are made on them by their attendance at nursing school and their entry and work in a very demanding profession. That these nurses are capable of providing information about the health education practices of traditional healers may be seen in table 4.16 and table 4.21, where the majority, 78 (92.9 %) indicated that traditional healers should participate in the primary level of prevention. Nurses should take note of the fact that traditional healers are adult learners whose readiness to learn is conditioned by their life tasks, responsibilities, roles, problems and expectations of the clients whom they serve (Oermann 1997:175). Since they themselves have been beneficiaries of tertiary education, community health nurses know from their own experience that the processes of adult learning are different from the learning process of children. Paedogogically sound and correct principles should be followed when teaching, training and instructing the traditional healers to become involved at the primary level of prevention. The most important principle of all in the training of adults such as traditional healers should be that their dignity as human beings and their

status as practitioners of an honourable and ancient form of medicine should be respected.

It is evident from this study that patients consult traditional healers before they consult nurses in clinics. This may be seen in the responses to question 1 in section B, where 94 (97.9 %) respondents supplied information which confirmed this hypothesis. It is evident that if traditional healers are effective in treating certain conditions (such as, for example, mental illnesses), more clients will consult traditional healers because they are readily available and accessible to their clients (see section B, question 19).

Because many Africans adhere to the cultural belief that diseases are caused by witchcraft and the dissatisfaction of the ancestors, they understandably consult traditional healers because they believe that traditional healers are qualified to treat them successfully (Pera & van Tonder 1996:237). Nurses should be sensitive to these beliefs and should under no circumstances belittle the cultural beliefs of patients who attend their clinics.

The majority of the respondents have 6-10 years experience and contributed positive opinions, beliefs, views and ideas. (See table 4.23.) According to Morrison (1993:30), past experiences impact on communication because they colour our judgements about our present situation. Nurses who have had negative encounters with traditional healers will know that traditional healers need education and training in health education. The same nurses know that clinics are not always accessible to clients and that traditional healers fill the gap in this regard. The training and education of traditional healers could empower them to deliver a better service to their clients – and this would benefit everyone in the community. The respondents indicated that integration or collaboration

is possible provided that appropriate training and education is given and provided that traditional healers are empowered with health education information.

All health care providers need to be sensitive towards cultural differences in their practice. The necessity for carefully designed and appropriate integration, collaboration and training was frequently emphasised in the opinions, views, beliefs and ideas of respondents. This indicates that respondents are highly positive towards the prospect of integrating traditional healers into primary health care. It should be noted, however, that the positive attitudes of respondents were qualified by various specific opinions as to how integration should take place and how it should be effected. See table 4.21 which shows that 78 respondents (92.9 %) indicated that traditional healers should participate at the primary level of prevention. Odi region (Odi, Brits and Moretele districts) provides a 24-hour service to the community in eleven (11) clinics throughout the region. Although these districts provide comprehensive services, many clients still have to travel distances of up to twenty one kilometres from their clinic to the referral hospital. It shows that the allocation of resources is inappropriate as far as the primary health care concept is concerned. The number of nurses allocated to each clinic indicates that a disproportion exists between nurse allocation and the statistics which reveal the incidence of minor ailments (see figure 4.9). The Director of Health in Odi region confirmed telephonically that the allocation is done according to a population-based model and perceived workload. The number of nurses allocated to the clinic influences the time the patient has to wait to receive primary health care. It is obvious therefore that if the clinic has too few nurses, clients will have to wait for a disproportionate amount of time before their consultation takes place. In such circumstances it is understandable that many patients will prefer to consult traditional healers

because they are much more readily accessible – especially in rural areas.

Residence in a rural environment is a factor that has a significant impact on the rate at which potential clients consult traditional healers because rural inhabitants are more strongly socialised to believe in the efficacy of witchcraft than their urban counterparts (see table 4.35). Respondents identified witchcraft as a problem that will hinder integration. Rural communities especially still believe that witchcraft causes disease. This is supported by Mvuyo (1992:36) who found that respondents believed that illness was attributable to witchcraft. See table 4.16 which shows that respondents indicate that witchcraft is a significant factor in the health education given by traditional healers. The results indicate that even though Odi region (Odi, Brits and Moretele districts) provides comprehensive health care (see Section A figure 4.12), large numbers of tuberculosis and psychiatric patients default on their treatment. If traditional healers are educated about the importance of impressing upon their clients that courses of treatment should be completed and if they are given the responsibility of ensuring that their patients take their medicine, one may expect that many more cures will be effected and maintained.

Differences in type among traditional healers influence the provision of primary health care and influence the choices which patients make about the kind of traditional healer which they wish to consult. It is the patients' inalienable right, as a unique individual, to choose the kind of healer whom he or she wishes to consult. Because *isangomas* and *umprofeti* form the majority of traditional healers in Odi region, more patients tend to consult healers of this kind (see section A, figure 4.13).

5.2.3 The attitude of community health nurses towards the integration of traditional healers into primary health care

The results indicate that respondents demonstrated different opinions, beliefs, views and ideas about the integration of traditional healers into primary health care delivery. The majority were willing to work with traditional healers but they were uncomfortable with their methods of examining the patients because many patients who have consulted traditional healers eventually arrive at clinics with complications (see table 4.12). Upvall (1992:32) 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. Nurses and traditional healers must focus on those health objectives which they have in common to ensure improved health care.

The majority of respondents answered "yes" to the integration option and suggested that several procedures should be performed by traditional healers (see table 4.18). Even though respondents were uncomfortable with methods used by traditional healers to examine their patients, the majority of the respondents, as indicated earlier, mentioned that traditional healers are effective in treating mental/psychiatric diseases and that they could be integrated at the primary level of prevention to promote health and prevent illness. This approach is supported by Pera and Van Tonder (1996:244) who state that traditional healers should be used in areas such as psychiatry, orthopaedics, gynaecology and idiopathic diseases.

An overwhelming majority of respondents have a positive attitude towards the integration of traditional healers in primary health care (see table 4.22). Community health nurses who participated in the research agreed on a referral system as traditional healers form part of the primary health care team. The respondents suggested training in health education for

effective integration. The necessity to train traditional healers appeared frequently amongst the opinions, beliefs, views and ideas of the respondents. This might therefore be the most effective strategy for integrating traditional healers into primary health care. The WHO's regional committee for Africa suggests the following steps if integration is to be successful:

- All traditional healers should be registered.
- Collaborative organisations for traditional healers should be promoted.
- Traditional healers should be legalised once they have passed competency tests.
- Research should be carried out into the medical knowledge of traditional healers.
- Where possible, traditional healers should be incorporated into health teams (WHO 1991: 9-35).

5.2.4 The role of traditional healers in the community

To understand the role of the traditional healer in the community it must be realised that some people have a dualistic approach to illness. They may adhere to Christian beliefs and customs while at the same time believing in and practising traditional rites and rituals. Many Africans, for example, believe that illness is caused by witchcraft and the dissatisfaction of the ancestors. For those who believe this, it is only logical to consult a traditional healer. Conditions that drive people to consult traditional healers are marital problems, work, children, family, love and poverty (Pera & Van Tonder 1996:237-238). Because many patients consult the traditional healers before consulting the clinic, it is understandable that nurses feel that traditional healers should be integrated to assist in health

promotion and disease prevention.

The majority of respondents support the participation of traditional healers in a health education programme which is designed to facilitate integration. The status of the traditional healers in the community should be utilized in health promotion and illness prevention. A reciprocal referral system will promote the status of these healers if they are recognised. As has already been mentioned, traditional healers are effective in the treatment of certain diseases and disorders. This fact should be respected and recognised in the integration strategy. When looking at the important status of the traditional healer in the community and the fact that he or she shares the values and beliefs of the people whom he or she serves, their contribution towards the provision of health services should not be underestimated. It is especially in the rural areas where there is a shortage of health care centres that traditional healers can play an important role (Pera & Van Tonder 1996:242).

It is important to note that costs, comfort, beliefs and values play a role in influencing the choice which a patient makes when he or she wishes to consult a health care provider. Because Western-type of health care is often inaccessible, there is often a lack of continuity in care and this means that the health needs of people are not being met (Pera & Van Tonder 1996:243).

5.2.5 Constraints which hinder integration

Table 4.32 shows that the overwhelming majority answered "yes" to the following statements:

- A lack of respect and trust towards traditional healers on the part of community health nurses will hamper integration. (95.7 %)

- Traditional healers lack standards and controls in the practice. (94.6 %)

- Traditional healers are effective in patient care. (94.6 %)

- Poor communication between traditional healers and community health nurses will interfere with integration. (98.9 %)

Poor communication was a major constraint between traditional healers and community health nurses. In communication various languages and means are used and these include verbal and nonverbal forms of communication. Poor communication could be caused by a mutual lack of respect and negative attitudes. Proper listening and observation will improve communication between traditional healers and community health nurses. Other constraints that may hinder integration are the following:

- Traditional healers are not able to monitor foetal heart rates.
- Both traditional healers and community health nurses lack appropriate knowledge and understanding about each other's professions.
- Community health nurses regard traditional healers as being unhygienic in their practice.

5.2.6 Ways of assisting with integration

The results indicate that traditional healers should be integrated by being properly selected, trained and then legalised in terms of an appropriate statutory law. This will prevent the health problems such as the complications which are seen in clinics and which have been so

extensively described in this study. Respondents selected the South African government and the South African Nursing Council as appropriate bodies to legalise the practice of traditional healers, subject to the completion of suitable training and any other form of education and training which they may need in order to function effectively as part of integrated health care teams. Effective integration presumes appropriate education, good communication, mutual respect, adherence to predetermined standards and the provision of appropriate facilities.

According to Mbigi and Maree (1995:111), working towards collective action (integration) presupposes five essential components. They are respect, dignity, solidarity, compassion and survival. Mbigi and Maree's approach is similar to that implicit in Leininger's model of transcultural nursing (Leininger 1991). The nurse must keep in mind that traditional healers adhere to a certain set of values and practices which enable them to be effective in their relationship with their clients and which help them to facilitate the recovery and well-being of their clients in a mutually understood cultural setting. If integration is to be successful, traditional healers should be carefully guided to adapt to the circumstances, practices and treatment of Western medicine by patient negotiation, assistance and education. They should at all times be treated with the respect and dignity which is due to their status as professionals and as human beings. At no time should they be treated with condescension, rudeness or impatience. It is important to bear in mind that they will be adapting as *adults* – and not as young novices or students – to the forms and practices of Western medicine. It is vital that any programme of education and training will give due consideration to the fact that traditional healers are already mature adults with viable practices in their own cultural setting and that they do not need any kind of training in Western medical or nursing practice in order for survival or to make a living. If integration programmes do not treat traditional healers with the

dignity and respect that they deserve, there will be a high drop-out rate – and such programmes will therefore be self-defeating. If, however, integration programmes are run by staff who are culturally sensitive, respectful and eager to help, there is little doubt that traditional healers will be enabled to reorder, change and modify their ways in the interests of both themselves and of their patients (Fitzpatrick and Whall 1996:185).

The majority of respondents were of the opinion that the following factors would assist with integration:

- An appropriately designed and certified form of training for traditional healers would ensure the safety of patients. (91 %)

- A properly organised and accredited referral system between traditional healers and community health nurses should be created. (83 %)

- Traditional healers should participate in health education programmes. (91 %)

There is little doubt that unless these goals, which were recommended by respondents, are incorporated into integration programmes, such programmes will not the successful.

5.3 FINDINGS ACCORDING TO LITERATURE

The information which the researcher derived from the literature indicates that the majority of the studies undertaken were medically orientated. The attitude of medical doctors tended on the whole to be negative towards integration because they focused on the unhygienic practices of traditional healers. Similarly, few nurses who conducted studies on integration,

collaboration and the possibilities of cooperation with traditional healers were positive about the prospects of such cooperation being successful. According to ANC (1994:55), traditional healers will become an integral and recognised part of the health care system in South Africa. Their recognition will certainly be a valuable precondition for successful integration.

A distinct lack of literature was found – especially literature about the integration of traditional healers. There is more information about collaboration and cooperation than there is about integration. Collaborative efforts have already been successfully initiated in other countries – especially in Botswana, Lesotho, Swaziland and Zimbabwe. The government of Swaziland and a United States agency have, as was mentioned earlier, implemented a programme to train traditional healers to educate their clients to prevent water-borne diseases. In this programme traditional healers were also taught how to prepare oral rehydration therapy and how to use it in rituals (Abdool-Karim et al 1994:12). Such successful experiments demonstrate that integration is possible if the people concerned are willing to listen to each other in the spirit of respect and recognition.

The respondents indicated that good communication, respect and recognition lead to effective integration so long as health care providers are willing to work as a team. Setswe (1999:59) recommended that the Department of Health should take the lead in formulating policies and should act to promote the training and use of traditional healers in primary health care. He further indicated that the Department of Health should ensure that traditional healers are incorporated as fully and effectively as possible because this will create an atmosphere of understanding, trust and respect between modern health workers, traditional healers and the community which they serve.

Various opinions, beliefs, views and ideas about possible methods of integration from both South Africa and abroad have been identified and described. Crawford (1995:291) was of the opinion that traditional healers should collaborate with biomedical personnel as they are in an excellent position to provide treatment for major psychiatric illnesses. As has already been noted, programmes outside South Africa for the training of traditional healers have been successfully implemented in a number of countries such as Nigeria. These programmes involved collaborative efforts among traditional healers and biomedical personnel. Traditional healers were trained in midwifery, gynaecology, prenatal and postnatal care. When traditional healers were evaluated at the end of these courses, it was found that the courses had improved the attitudes and practices of traditional healers (Abdool-Karim et al 1994:12). It was found that community health nurses were positive towards the integration of traditional healers into the health care system provided that they are first trained and empowered with the necessary knowledge to make their practice more effective.

5.4 CONCLUSIONS

The formulated objectives were evaluated and achieved according to the data, findings and literature collected. The following conclusions are based on the objectives which were set by the researcher.

OBJECTIVE 1

Identify the attitude of community health nurses towards the integration of traditional healers in primary health care.

This objective identified the attitude of community health nurses towards the integration of traditional healers into primary health care. Different

ideas, views, opinions and beliefs were obtained. The integration of traditional healers into primary health care was emphasised. These findings showed that the respondents were positive towards the idea of integration provided that traditional healers were properly selected, trained and constituted as professionals statutory legislation appropriate to their profession. It is concluded that traditional healers should be fully empowered with the skills of need identification, diagnosis and the management of clients. Shai-Mahoko (1997:137) is of the opinion that traditional healers should be included in the immunization schedule. Such participation will contribute towards their empowerment if they cooperate fully and effectively with community health nurses. It is also necessary for community health nurses to improve their attitude towards traditional healers if they wish to provide clients with holistic care.

OBJECTIVE 2

Identify and describe the role of traditional healers in the community.

Different roles for traditional healers were identified. The information obtained from community health nurses shows that traditional healers should be involved in the HIV/AIDS prevention programme. This was also confirmed by Swift and Strang (1993:690-691) in their study of health promotion and illness prevention. Proper utilization will reduce infection and mortality rates in South Africa as the country is rapidly being overwhelmed by the HIV/AIDS pandemic – not to mention very high rates of infection in those in contact with tuberculosis and various sexually transmitted diseases. The statistics which emphasise the seriousness of the HIV/AIDS pandemic have been brought to public attention again and again by the Department of Health (1997:140), and the department's line is now that individuals should play a much more active role in caring for their own health and preventing infection. This research has highlighted the fact that traditional healers are indispensable in the provision of health

care to the community because they are:

- people who are respected and highly regarded in the community.
- often far more accessible and available to the community than Western biomedical staff– especially in rural and disadvantaged areas.

Although many traditional healers currently lack certain skills in health promotion and illness prevention, they are respected and are always accessible to help members of their communities (see table 4.31). The successful incorporation and integration of traditional healers into the health care system will contribute to a better quality of life for all South Africans.

OBJECTIVE 3

Identify the factors which constrain traditional healers from being integrated into primary health care.

This objective identified the following problems as constraints which hindered integration:

- A lack of respect and trust
- A lack of commonly agreed to standards and controls amongst traditional healers
- Poor communication
- Lack of facilities
- Differences in healing practices
- Various attitudes on the part of both traditional healers and community health care nurses

Respondents rated *poor communication* most highly among all these constraints (see table 4.31). This indicates that poor communication is the

most significant factor which hampers the integration of traditional healers into the health care system. Although poor communication is attributable to both traditional healers and community health nurses, there is no reason why both sides should not learn to communicate very well indeed if attitudes of respect and trust are adopted on both sides.

Bodibe's (1988:80) research has shown that traditional healers are not prepared to share their knowledge of traditional healing – basically because they feel insecure and uncertain about how they will be received. This lack of trust on the part of traditional healers is almost certainly attributable to the condescending and dismissive attitudes displayed by many members of the Western biomedical professions. Until the latter learn to treat traditional healers with respect, trust and dignity which they deserve, no diminution of negative attitudes towards biomedical health care providers can be expected. Until traditional healers are treated as professionals in their own right, they must not be expected to share their knowledge with outsiders.

OBJECTIVE 4

Ways of facilitating the integration of traditional healers into primary health care should be identified.

This objective acted as the basis for identifying various ways and means of integrating traditional healers into primary health care. Several ways and means were identified in the research.

The cause of integration will only be advanced if the constraints which hinder integration are identified, tackled and eliminated. The proper emphasis in this regard should be on the improvement of communication by means of good manners and respectful attitudes and on the increased sensitivity of all those care providers who provide culturally congruent

primary health care.

It was concluded that traditional healers should be selected and properly trained according to appropriate and predetermined standards, and that their status and practices should be legalised by an appropriate act of parliament (statutory law) which will codify those standards of practice and exercise control which will ensure the safety of patients.

5.5 RECOMMENDATIONS

In the light of the findings and problems identified in this study, the researcher makes the following recommendations:

- The Department of Health should ensure that integration between traditional healers and community health nurses takes place at a national level. Strategies to ensure the integration of both kinds of health providers should be designed and implemented.

- The government (the Department of Health) should take the responsibility of ensuring that traditional healers undergo a recognised form of selection and training, and that their profession should be legalised by means of statutory law so that registered traditional healers are obliged to conform to predetermined standards of practice.

- Community health nurses should conduct in-service education and workshops which will give traditional healers the opportunity to participate in health education programmes that will empower them to educate their clients to avoid common infections and illnesses such as HIV/AIDS.

- All participants in integration programmes (but especially traditional healers and community health nurses) should be educated in transcultural communication skills so each individual is capable of communicating well and demonstrating the necessary levels of respect, recognition and sensitivity towards those whose practice is based on different paradigms and traditions.

- The government (the Department of Health) should provide regular in-service education programmes for traditional healers and community health nurses so that the differences in the provision of health care can be understood and accommodated.

- The training of nurses should be based on a curriculum that incorporates multicultural perspectives. Nurses should be taught the fundamentals of African traditional medicine. This will enable them to understand why patients consult traditional healers.

- A well-established referral system should be developed and referral should be reciprocal. Consulting rooms should be provided for traditional healers so that they can consult their clients when clients ask community health nurses to be referred to traditional healers. Consulting rooms for traditional healers should be in the same clinic that houses the consulting rooms of community health nurses so that traditional healers and community health nurses can share their ideas about the management of clients.

- A health promotion model which complements other health protection and promotion models should be developed. Such models should be able to empower traditional healers in their daily practice. Educational principles could be used to guide the

selection of health information for individuals, families and community workshops, and in-service education workshops should be regularly organised so that the models can be applied to traditional healers (Stanhope & Lancaster 1993: 252-254).

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

- The following factors need further investigation:

- the attitude of traditional healers towards their own integration in primary health care

- the attitudes of clients to the integration of the two kinds of health care teams

- strategies which could empower traditional healers on health issues

5.7 IMPLICATIONS FOR NURSING PRACTICE

5.7.1 For nursing education

Nursing syllabuses in South Africa should all be designed in terms of transcultural principles and all nurses should be trained in the techniques of multicultural nursing and care giving. Nurses must be taught to be self-reflective about their own cultural premises. They should also be taught to view their own attitudes and health beliefs objectively and to respect the attitudes and beliefs of those whose health care practices are based on culturally alien paradigms. Above all, nurses should be taught not to impose their own prejudices and attitudes onto their patients.

5.7.2 For community health nursing

Nurses should be allocated to rural communities so that they can empower such communities to make their own choices about health care and so that they can teach members of the community the basics of health practice and self-care.

5.7.3 For policy making

The South African government needs to pass legislation that will grant professional status to the various categories of traditional healers. Such legislation will systematise practice of traditional healing and in so doing, set certain standards which will benefit both traditional healers and their clients. Although there will be a transitional period during which practising traditional healers will be selected, educated, trained and certified in terms of the new legislation, it is traditional healers themselves (quite apart from their clients) who stand to gain if their practice is subject to the control and regulation of their own professional body. It is envisaged that the current success rate which traditional healers enjoy in treating certain conditions will be even more improved once the profession is subject to a self-controlling professional organisation constituted in terms of statutory legislation. Thus, as was noted before, traditional healers are extremely successful in treating certain kinds of mental illnesses (see table 4.8). The range of treatment which traditional healers currently apply will be standardised and extended once the profession is controlled by its own professional body. Thus, for example, although traditional healers cannot currently legally prescribe drugs on restricted schedules, they might well be empowered to do so in terms of appropriately defined legislation.

5.7.4 For nurse administrators

Nurse administrators should provide as much information as they can to their subordinates about how transcultural beliefs affect patient care. This information can be provided in staff development programmes. All employees should be constantly updated with information about traditional practice.

5.7.5 For research

The findings of this study suggest that further research is needed on a variety of topics, but especially on:

- medicines used by traditional healers
- traditional healers' methods of examination
- the future of traditional healers
- studies which compare the attitudes of nurses and traditional healers towards integration

5.8 LIMITATIONS OF THE STUDY

The research was limited to the population of only three districts of one province (North West Province). As populations differ from one province to another, the results were not representative. South Africa is called "the rainbow nation" because of the diversity of its population, and so any scientific study of this kind has to be replicated and qualified with further research in other regions of South Africa. The ideas, opinions and views

indicated by respondents could not be linked to the ideas, opinions and views of nurses in other provinces.

The question which solicited information about the number of children per individual respondent also contained some inherent limitations. There was also a need for individual respondents to provide information based on the number of their children and whether respondents had ever taken their children to traditional healers. It would also have been useful to know the reasons why respondents had taken their children to traditional healers as this would have provided essential information. The question about the number of children used ranges and ranges do not give sufficiently specific information (in this case).

The findings on the number of nurses allocated per clinic reveal a limitation when these are compared to the statistics. There are no standing rules or guidelines about how many nurses are supposed to be allocated to each clinic. The Director of Health (Odi region) was contacted telephonically and he indicated that allocation is based on population model and workload. There is also a limitation inherent in the question which was asked. Comparative data analysis would have been useful for comparing the number of nurses in the clinics with the statistics from that clinic and would have enabled the researcher to work out the default rate.

5.9 FINAL CONCLUSIONS

The study has provided much useful information about attitudes to the issue of integrating traditional healers into the primary health care system. Constraints which hindered integration were identified and the ways to facilitating integration were discussed. The research shows that the attitudes of respondents to the possibility of integration was, on the whole, extremely positive – subject to certain qualifications on the part of the

respondents, which emerged very clearly. This indicates and the integration of traditional healers into the primary health care system of South Africa is a viable project that should be implemented from the highest level of government. Kriel (1989:211) writes:

> *It is hoped that the insights obtained will also have a sobering effect on impatient outsiders who have dealings with Africans. Let them consider that the ancient traditions, whatever may be said against them and whatever the futility of constructing a future on them, did indeed afford deep emotional security.*

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ANNEXURES

ANNEXURE A

Letter of acceptance for research proposal

ANNEXURE A

Faculty of Arts

Fakulteit Lettere en Wysbegeerte

DEPARTMENT OF ADVANCED NURSING SCIENCES
TELEPHONE NUMBER (012) 429-6213
FAX NUMBER (012) 429-6866

Mrs MD Peu
PO Box 161
Temba
0407

02 February 1999

Dear Mrs Peu

ACCEPTANCE OF RESEARCH PROPOSAL BY THE ETHICS AND RESEARCH COMMITTEE OF THE DEPARTMENT OF ADVANCED NURSING SCIENCES UNISA FOR THE DEGREE MA(CUR)

Your title 'The attitude of community health nurses towards integration of traditional healers in primary health care in the North West Province' as well as your proposal have been accepted by the ethics and research committee of the University of South Africa on 25 June 1998. Your supervisor is Prof R Troskie with Mrs SP Hattingh as joint supervisior

The questionnare as instrument is acceptable but must be pretested as soon as you get permission from the Department of Health in the North West Province

Kind regards

[Prof R Troskie]

HEAD: DEPARTMENT OF ADVANCED NURSING SCIENCES

ANNEXURE B

Questionnaire

ANNEXURE B

QUESTIONNAIRE

I will appreciate your participation in completing this questionnaire. The questionnaire consists of seven sections. Please answer all questions by marking the appropriate block with an X. Use one X per block.

SECTION A

FOR OFFICIAL USE
Questionnaire

DEMOGRAPHICAL DATA = 1-3

1. Sex

Male	1	= 4
Female	2	

2. Age

0-20	1	
21-40	2	
41-60	3	= 5
61-+	4	

3. Marital status

Married	1	
Single	2	
Widow/widower	3	= 6
Divorced	4	
Separated	5	

4. Religious affiliation (church)

Lutheran	1	
Dutch Reformed	2	
Apostolic	3	
Roman Catholic	4	= 7
Z.C.C.	5	
A.M.E.	6	
Presbyterian	7	
Other (specify)	8	

SECTION A

FOR OFFICIAL USE

5. Ethic group

Xhosa	1
Zulu	2
Tswana	3
N.Sotho	4
Venda	5
Tsonga	6
Afrikaans	7
English	8
S.Sotho	9
Ndebele	10
Swazi	11

[ ] = 8-9

6. Citizenship

South African	1
Other (specify)	2

[ ] = 10

7. Home area

Town	1
Village	2
Township	3

[ ] = 11

8. How many children do you have?

0-2	1
3-4	2
5-8	3

[ ] = 12

9. Highest standard passed.

None	1
Sub A - std 2	2
Std 3-6	3
Std 7-10	4
Post secondary qualifications	5

[ ] = 13

SECTION A

10. Professional qualifications	Yes	No	
General nurse	1	2	= 14
Midwife	1	2	= 15
Community health nursing	1	2	= 16
Psychiatry	1	2	= 17
Other(specify)	1	2	= 18

11. Years of experience		
0-5 years	1	
6-10 years	2	
11-15 years	3	= 19
16-20 years	4	
21 and above	5	

12. District of work		
Odi	1	
Brits	2	= 20
Marital	3	

13. Distance of referral hospital		
0-10 km	1	
11-20 km	2	= 21
21 km +	3	

14. Number of clinics in the district		
	1	
	2	
	3	
	4	
	5	=22-23
	6	
	7	
	8	
	9	
	10	
	11+	

SECTION A

FOR OFFICIAL USE

15. How many community health nurses are in your clinic?

1-5	1
6-10	2
11-15	3
16-20	4
21 and above	5

[ ] = 24

16. The type of community that you are rendering service to is:

Rural	1
Urban	2

[ ] = 25

17. Statistics of approximate number of daily attendance's for minor ailments is:

1-50	1
51-100	2
101-200	3
201and above	4

[ ] = 26

18. Statistics of approximate number of monthly attendance for psychiatric patients:

1-20	1
21-50	2
51-100	3
101+	4

[ ] = 27

19. Statistics of approximate number of monthly attendance for TB patients:

1-10	1
11-20	2
21-50	3
61+	4

[ ] = 28

SECTION A

FOR OFFICIAL USE

20. Statistics of approximate number of defaulters per month (poor attendance).

20.1 Psychiatric patients:	0-10	1	
	11-20	2	= 29
	21-40	3	
	41 and above	4	
20.2 TB:	0-10	1	
	11-20	2	= 30
	21-40	3	
	41 and above	4	

21. The type of clinic service rendered.

24 hour clinic	1	= 31
Day clinic	2	

22. Service provided

	Yes	No	
Family Planning	1	2	= 32
Mother and child	1	2	= 33
Under fives	1	2	= 34
Psychiatric	1	2	= 35
Underweight	1	2	= 36
Minor ailment	1	2	= 37
TB	1	2	= 38
All of above	1	2	= 39

23. Do you have traditional healers in your community?

Yes	1	= 40
No	2	

SECTION A

FOR OFFICIAL USE

24. If yes, indicate the type(s) of traditional healers.	Yes	No		
Traditional birth attendant	1	2		= 41
Isangoma	1	2		= 42
Herbalist	1	2		= 43
Sangoma-profeti	1	2		= 44
Sangoma-profeti attendant	1	2		= 45
Inyanga	1	2		= 46
Umprofeti	1	2		= 47
Others (specify)	1	2		= 48

SECTION B

FOR OFFICIAL USE

In this section information regarding your opinion, beliefs, views and ideas is required towards integration of traditional healers in primary health care. Indicate with an X in an appropriate block or provide required information on the space provided.

1. Do patients in your area consult traditional healers?

Yes	1	= 49
No	2	

2. Do male patients consult traditional healers more frequently than female patients?

Yes	1	= 50
No	2	

3. Do older patients consult traditional healers more frequently than younger patients?

Yes	1	= 51
No	2	

4. Common disease that are taken to traditional healers.

	Always	Seldom	Never	
Diarrhoea/Vomiting	1	2	3	= 52
High blood pressure	1	2	3	= 53
Diabetes Mellitus	1	2	3	= 54
Psychiatric illness	1	2	3	= 55
Other (specify)	1	2	3	= 56

5. How much do patients pay for consulting traditional healers?

R1-R100	1	
R101-R500	2	= 57
R501-R1000	3	
R1001+	4	

6. What other kind of payment can patients make?

.....

.....

.....

SECTION B

FOR OFFICIAL USE

7. What method are used by traditional healers to examine patients?

_____

_____

_____

_____

8. Do you feel comfortable with methods of examination of traditional healers?

Yes	1	= 58
No	2	

9. If no, support your statement.

10. What is the most common method of treatment used by traditional healers?

	Always	Some-times	Seldom	Never	
Oral	1	2	3	3	= 59
Rectal	1	2	3	3	= 60
Inoculation	1	2	3	3	= 61
Steam inhalation	1	2	3	3	= 62
Spiritual	1	2	3	3	= 63

11. Have you ever consulted patients referred from traditional healers?

Yes	1	= 64
No	2	

12. Do patients bring along a referral note?

Yes	1	= 65
No	2	

SECTION B

FOR OFFICIAL USE

13. Do patients consult the clinic at advanced stage of illness?

Yes	1
No	2

[ ] = 66

14. If yes, give reasons.

_____

_____

_____

_____

15. What type of health educations are given to patients by traditional healers?

_____

_____

_____

_____

16. Do you feel that traditional healers should be integrated in primary health care?

Yes	1
No	2

[ ] = 67

17. If integrated should a traditional healer be provided with facilities?

Yes	1
No	2

[ ] = 68

18. If yes, what procedures or activities should be done by traditional healers if they are integrated?

_____

_____

_____

_____

SECTION B

FOR OFFICIAL USE

19. Do you think traditional healers are effective in treating certain diseases?

Yes	1
No	2

[ ] = 69

20. If yes, identify those diseases.

_____

_____

_____

_____

21. Traditional healers should be integrated in the following level of prevention.

	Yes	No	
Primary prevention	1	2	[ ] = 70
Secondary prevention	1	2	[ ] = 71
Tertiary prevention	1	2	[ ] = 72

_____

22. Support the answer chosen from above (21).

_____

_____

_____

_____

SECTION C

FOR OFFICIAL USE

Please indicate to what extend you agree or disagree with the statement below. Mark the appropriate column with an X.

1. Patients should consult traditional healers for their health problems.

Agree	1
Disagree	2
Uncertain	3

[ ] =73

2. Patients should visit the clinic before consulting traditional healers.

Agree	1
Disagree	2
Uncertain	3

[ ] = 74

3. Community health nurses should accept referral note from traditional healer.

Agree	1
Disagree	2
Uncertain	3

[ ] = 75

4. Community health nurses should refer patient to traditional healer if patient request.

Agree	1
Disagree	2
Uncertain	3

[ ] = 76

5. Traditional healers should be encouraged to refer patients to clinics immediately after consultation.

Agree	1
Disagree	2
Uncertain	3

[ ] = 77

6. Traditional healers should form part of primary health care team.

Agree	1
Disagree	2
Uncertain	3

[ ] = 78

SECTION D FOR OFFICIAL USE

In this section you are required to provide relevant information regarding general information that is not mentioned in the questionnaire. Fill in the information required in the space provided.

1. What are your opinions, beliefs and ideas regarding integration of traditional healers in primary health care?

2. Beliefs

3. Views

4. Ideas

SECTION E

FOR OFFICIAL USE

In this section you are required to provide relevant information regarding the role of traditional healers in the community. Provide answers to space provided or mark with an X where indicated.

1. Traditional healer is a person who is respected and recognised by the community.

True	1	= 79
False	2	

2. Traditional healers provide care to the community.

True	1	= 80
False	2	

3. Traditional healers act as leaders in the community.

True	1	= 81
False	2	

4. Traditional healers should participate in health education programme.

True	1	= 82
False	2	

5. Traditional healers treat certain physical and mental diseases effectively.

True	1	= 83
False	2	

6. Traditional healers are acceptable, accessible and available.

True	1	= 84
False	2	

7. Traditional healers are more involved in community care.

True	1	= 85
False	2	

8. Traditional healers cause family disorganisation in the family.

True	1	= 86
False	2	

SECTION F FOR OFFICIAL USE

In this section you are required to provide the information regarding problems as constraints towards integration. Provide the required information on the space provided or mark with an X where indicated.

1. Lack of respect and trust from traditional healers and community health nurses will hamper integration.

Yes	1	= 87
No	2	

2. Traditional healers lack standards and controls in their practice.

Yes	1	= 88
No	2	

3. Traditional healers are effective in patient care.

Yes	1	= 89
No	2	

4. Poor communication between traditional healers and community health nurses will interfere with integration.

Yes	1	= 90
No	2	

5. Identify problems that may prevent integration of traditional healers in primary health care.

_____

_____

_____

_____

SECTION G

FOR OFFICIAL USE

Provide the information regarding ways of assisting with integration of traditional healers in primary health care. Provide the information in space provided or mark with an X where indicated.

1. Traditional healers should conform to certain standard within formal sector.

Yes	1
No	2

[ ] = 91

2. If no, support your answer.

_____

_____

_____

_____

3. Traditional healers should be properly selected for integration according to set standards

Yes	1
No	2

[ ] = 92

4. If yes, how are they supposed to be selected?

_____

_____

_____

_____

5. Traditional healers should be legalised.

Yes	1
No	2

[ ] = 93

6. If yes, who should legalise traditional healers?

_____

_____

_____

_____

SECTION G

FOR OFFICIAL USE

6. Traditional healers should undergo recognised training to ensure patient safety.

Yes	1	= 94
No	2	

7. Consulting room for traditional healers should be created at the clinic where community health nurses jointly with traditional healers work together.

Yes	1	= 95
No	2	

8. Recognised referral system between traditional healers and community health nurses should be created.

Yes	1	= 96
No	2	

9. Traditional healers should participate in health education programme.

Yes	1	= 97
No	2	

10. Is there anything else you would like to comment on or say in assisting integration.

_____

_____

_____

COULD YOU PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED.
THANK YOU FOR YOUR PARTICIPATION.

ANNEXURE C

Request to conduct research

ANNEXURE C

University of Pretoria
Department of Nursing Science
P O Box 667
PRETORIA
0001

28 January 1999

Director General
Private Bag X2058
MMABATHO
2735

Dear Sir

REQUEST TO CONDUCT RESEARCH

I hereby request permission to conduct research in Northwest Province especially at Odi and Rustenburg regions. I am a master's student at University of South Africa but currently working as a lecturer at University of Pretoria. My student number is 692-224-4. The title of my research project is:

"The attitude of community health nurses towards integration of traditional healers in primary health care in Northwest Province".

This research project is done under the supervision of Professor T R Troskie and joint promotor Mrs S P Hattingh.

Community health nurses who are providing primary health care will be subjects of interests.

The purpose of this research is to:-

- identify the attitude of community health nurses towards integration of traditional healers in primary health care;

- identify the role of traditional healers in the community;

- identify the constraints towards integration of traditional healers in primary health care;

- determine the ways of assisting with the integration of traditional healers in primary health care;

Questionnaire will be handed personally or posted to the clinics. Completion of questionnaire will take 20-30 minutes.

Confidentiality will be ensured. No names nor addresses will be required from the subjects. Questionnaire numbers will be used for control measures. I will provide my telephone and address to all subjects for any problem clarification. Participation is voluntary and if one wishes to withdraw one is at liberty to do so.

Your anticipated consideration of and speedy response to this request will be greatly appreciated.

Mmapheko Doriccah Peu (Mrs)
M A (Cur) student

ANNEXURE D

Permission to conduct research

ANNEXURE D

DEPT OF HEALTH AND DEVELOPMENTAL SOCIAL WELFARE
ODI DISTRICT OFFICE
ACTING REGIONAL MANAGER: MRW.T.VIVIAN

ENQ.: MR W.T.VIVIAN
TEL.: 012-7026682
FAX.: 012-7021610/ 7026683

ODI DISTRICT OFFICE
PRIVATE BAG X509
MABOPANE
0190

February 17, 1999

Mrs Peu
Unisa
PRETORIA

RE : RESEARCH PROPOSAL

You are hereby permitted to conduct your study in the region as approved by Unisa.

This approval is on provision that you commit yourself to presenting the region with your final research report. Hoping that you understand the importance of communicating your results with the subjects and other important stakeholders.

W.T. Vivian
P.P. REGIONAL MANAGER

DEPT. OF HEALTH AND DEVELOPMENT
SOCIAL WELFARE
INTEGRATED NUTRITION PROGRAMME
1999 -02- 22
FAR EASTERN REGION
NORTH WEST PROVINCE

ANNEXURE E

Brits district clinics

ANNEXURE E

Developmental Social Welfare
Private Bag X5084
BRITS
0250

TEL: (012) 2523766/7/8

FAX: (012) 2523769

ENQUIRIES: Ms. D.L. Magano

DATE: 23 April 1999

Attention: Mrs M.D. Peu
University of Pretoria

Madam,

RE: RESPONSE TO YOUR FAX

Thank you very much for choosing our clinics for your research project. We hope that we will also benefit from your findings.

Find the names of the clinics as requested.

	CLINICS	MANAGER PERSON-IN-CHARGE	TEL NO:
	Letlhabile	CPN. C. Hlatswayo	(012) – 2510774
X	Bapong	CPN. D. Rametsi	(012) – 2566030
	Bethanie	CPN J. More	-
X	Mothotlung	CPN E. Ngwenya	(012) 7092287
	Brits Gateway	CPN S. Steyn	(012) 2523311
X	Sonop	SPN M. Chabalala	(012) 2566637/8

Thank you.

GOOD LUCK I N YOUR VENTURE

Best Regards.

MRS. M.F. RAKAU
DISTICT MANAGER
Magano/2/Mb28-99

ANNEXURE F

Odi district clinics

ANNEXURE F

ODI DISTRICT

INSTITUTION	TELEPHONE NUMBER
Phedisong 1	(012) 703-3978
Phedisong 4	(012) 703-2993
Phedisong 6	(012) 703-4700
Hoekfontein	(012) 703-3201
Hebron	(012) 563-0199
Rabokala	083 310 5223
Tlamelong	(012) 702-1101
Boekenhout	(012) 702-1495
Sedilega	(012) 702-2300
Klipgat	083 310 5216
Madidi	083 109 4994
Jericho	(012) 729-1036
Maboloka	083 310 5217
Kgabo	(012) 704-0127/8
Dube (Winterveldt)	(012) 704-0135
Mpho ya Batho	083 109 1202
Refentse	083 109 3212
Moiletswane	083 109 5737
Pabalelo	(012) 703-3591
Itireleng	(012) 703-2291
Odi Hospital	(012) 702-2274/5/6/7/8

ANNEXURE G

Moretele district clinics

MORETELE DISTRICT

CLINICS	
Babelegi	
Bosplaas	X
Dikebu	
Dilopye	X
Ga-mmotla	
Kekanastad	X
Kgomo kgomo	
Lebotlwane	X
Makapanstad	
Mathibestad	X
Maubane	
Mogogelo	X
Moretele	
Ngobi	X
Ramotse	
Refenste	X
Ratjiepan	
Stinkwater	X
Syferkuil	
Temba	X
Thulwe	
Tladistad	X
Moretele mobiles	
Jubilee Hospital	X

ANNEXURE H

Statistics course on data analysis

ANNEXURE H

Background to and Use of Basic SPSS Procedures

Presented at UNISA

We hereby certify that:

Mrs Mmapheko D Peu

completed the above mentioned course on:

5 - 9 July 1999

PRESENTER

HEAD: RESEARCH SUPPORT