TITLE: INVESTIGATIONOF INTER-PROFESSIONAL COLLABORATIONBETWEEN TRADITIONAL HEALTH PRACTITIONERSANDCOMMUNITYNURSES AT PRIMARY HEALTH CARE IN THE NGAKA MODIRI MOLEMA DISTRICT IN THE NORTH WEST PROVINCE (NWP).

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DISSERTATION SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE MASTERS DEGREE IN COMMUNITY NURSING SCIENCE IN THE FACULTY OF AGRICULTURE, SCIENCE AND TECHNOLOGY AT NORTH WEST UNIVERSITY: MAFIKENG CAMPUS

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DECLARATION

I MONTSHIOA MAMOTALE GLADYS student number: 22080805,hereby declare that this research is my original work. Unless specifically stated, all references listed have been consulted. The work of this dissertation is a record that has been done by me and has not been previously accepted for any higher degree or professional qualification at any other educational institution.

Signed _____

MRS MONTSHIOA MAMOTALE GLADYS

Date: 21/10/2012

This dissertation has been submitted with my approval as a university supervisor and would certify that the requirements for Masters in Nursing: Community Nursing Science degree rules and regulations have been fulfilled.

Signed _____

PROFESSOR USHOTANEFE USEH

Date: 22/10/12

Signed _____

Dr. MOFATIKI EVA MANYEDI

Date: 22/10/2012

DEDICATION

This study is dedicated to: my late husband kgosi Setumo Stephen Montshioa, my late parents, kgosi Mogawane Simon and Serite Lilly Moshoette and my late parents in – law kgosi Lapologang Fred and Mmanthonyane Lydia Montshioa. May their souls rest in peace.

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ABBREVIATIONS AND ACRONYMS

- Acquired Immuno Deficiency Syndrome : AIDS
- Adult Basic Education Training : ABET
- African Medical Research and Foundation :AMREF
- African National Congress : ANC
- African Traditional Medicine : ATM
- African Union : AU
- Biomedical Health Practitioners : BHPs
- Community Nurses : CNs
- Community Health Centres : CHCs
- Department of Health : DoH
- Directly Observed Treatment Strategy : DOTS
- Staff Nurses : SNs
- Auxiliary Nurses : ANs
- HealthCare Professionals : HCPs
- Human Immunodefiency Virus : HIV
- Interim Traditional Health Practitioners Council : ITHPC
- Inter-Professional Collaboration : IPC
- Medical Association of South Africa : MASA
- National Department of Health : NDoH
- Ngaka Modiri Molema : NMM
- North West Province : NWP.
- Primary Health Care : PHC
- Professional Nurses : PNs
- Sexually Transmitted Infections : STIs
- South Africa : SA
- South African Nursing Council : SANC
- Southern African Development Community : SADC
- Statistical Package for Social Sciences : SPSS

- Traditional Birth Attendants : TBAs
- Traditional Health Organization : THO
- Traditional Health Practitioners : THPs
- Tuberculosis : TB
- Joint United Nations Programme on HIV/AIDS : UNAIDS
- World Health Organization : WHO

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Abstract

This study investigated and described the nature and extent of inter-professional collaboration between the Traditional Health Practitioners (THPs) and Community Nurses (CNs) in Primary Health Care (PHC) in the Ngaka Modiri Molema (NMM) district of North West Province of South Africa.

Methodology: A quantitative cross-sectional survey design was used in this study. Data was collected with a self constructed questionnaire from 264 CNs and 217 THPs in the five sub districts of NMM. Descriptive data was analyzed using Statistical Package for Social Science (SPSS) version 20.

Findings: Majority (76%) of healthcare professionals were females. There was no significant relationship between the respondents' age, gender and educational level towards inter-professional collaboration ($p>0.05$). A total of 162 (82, 2%) of CNs and 205 (95, 8%) of THPs indicated that they respect each other as healthcare professionals in their own right. The high percentage of respect was an expectation of positive inter-professional collaboration. Mutual respect is key element to success between and among the professionals. A total of 69, 6% of CNs would not advise patients to consult THPs whereas (97, 2%) of THPs would advice patients to consult CNs. A total of 191 (95 %) of CNs have never referred patients to THPs. The study revealed that 204 (95, 3 %) of the THPs indicated that they will refer patients to the CNs without fear, guilt or insecurity. Majority of healthcare professionals, that is 177 (68, 8%) of CNs and 148 (92, 1%) of THPs support working together.

Conclusion

This study revealed that the there was no significant association between inter-professional collaboration between the THPs and CNs at PHC in Ngaka Modiri Molema; however, there was willingness by healthcare professionals to collaborate.

Key words: Inter-professional collaboration; Traditional Health Practitioners (THPs); Community Nurses (CNs); Primary Health Care (PHC).

CHAPTER 1

1.1 Introduction and Background

The South African communities are diverse, a rainbow nation; with a variety of ideas or practices about health and ill health. A high percentage of the indigenous African population still relies or consults with Traditional Health Practitioners (THPs) for healthcare services. Sometimes consultations for healthcare are done simultaneously with orthodox or Western medical practitioners. Culture and belief systems have been known to influence the use of these traditional preparations. When this happens, the traditional health and Western health practitioners are seldom aware of these simultaneous visits. It is not known if these simultaneous visits to traditional health practitioners complement or contradict each other. Collaboration between the two healthcare practitioners is essential for proper and effective healthcare and or promotion and prevention of hazards associated with drugs and traditional medicines preparations.

UNAIDS (2000:34) indicated that there is a need for developing a lasting collaboration between the two professionals that need a concerted effort from stakeholders. Vaka, Stewart, Foliaki and Tu'itahi (2009: 93) conducted a study in Tongan and highlighted that there is scope for Western healthcare approaches to operate alongside THPs approaches as long as suitable, mutually respectful and understanding attitude is adopted. They further revealed that, the Western Healthcare Professionals reported being relatively open to working with THPs to respond to culturally responsive and appropriate healthcare services.

South Africa is practicing a pluralistic healthcare system (van Rensburg, 2009:506; Tjale and de Villiers, 2004:144; Wreford, 2005:55).This system has evolved from different origins. The two main contributors of healthcare systems are: Western medicine; in this context referred to as Community Nurses (CNs) and the various African cultures with their traditional tribal medicines; in this context referred to as THPs. This has resulted in the development of two healthcare systems in this country, alongside each other with Western medicine having the official

status(Dennil, King &,Swanepoel, 2007:34; van Rensburg, 2009:507;Tjale, 2004:144;van wyk, 2009:64; Robins,2009:7).As these systems have been known to work in isolation, collaboration within them is essential for effective healthcare delivery and practice.

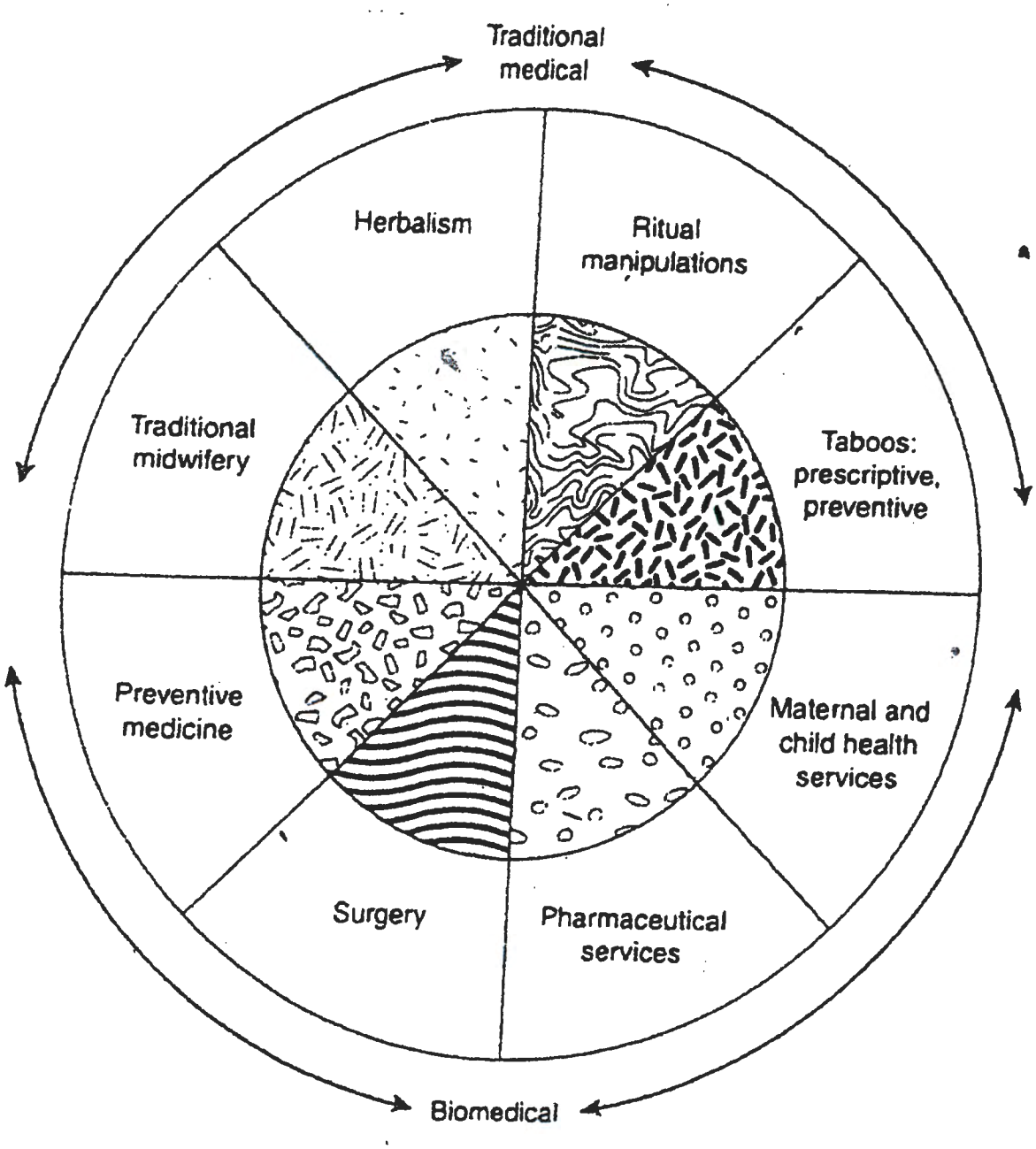

Figure 1.1: Corresponding aspects of the traditional medical model and Biomedical model

Source: Spring in (van Rensburg, 2009:546)

Figure 1.1 serves as a conceptualization of conditions and circumstances for possible inter-professional collaboration between the THPs and CNs. The designs on the model are just to show corresponding aspects for both traditional and biomedical models. It is apparent that every aspect of traditional medical system is analogous with a corresponding aspect of the modern biomedical system, and vice versa. Herbalism is analogous with pharmaceutical services. Traditional midwifery which encompasses Traditional Birth Attendants (TBAs) is analogous with maternal and child health services. The surgical aspects of modern medicine corresponds with rituals manipulations in traditional systems, for an example traditional circumcision, cupping and extraction of foreign objects. Taboos: are prescriptive and preventive; and aim at prescribing appropriate health behaviours and prohibiting health threatening behaviours; this aspect is analogous with preventive health measures in the modern biomedical system (van Rensburg, 2009:545.

The above model represents various aspects of healthcare services that are provided by both healthcare professionals; this could form a good basis for Inter-professional collaboration between the THPs and CNs in providing a variety of healthcare services through diversified healthcare approaches.

The use of both healthcare systems has been suggested by some researchers such as Kayombo, Uiso, Mbwambo, Mahunnah, Moshi and Mgonda (2007:2) who highlighted that handling the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) epidemic; requires a mobilization of existing and potential resources of two healthcare systems for coordinated controlled effort from grassroots to national level. Thus the need for collaboration of two healthcare systems is now important in sub-Saharan Africa due to the ever increasing burden of HIV/AIDS. Kayombo et al. (2007:2) further indicated that initiating collaboration requires building mutual respect between the biomedical and THPs through dialogue on matters of interest and stressing the complementary nature of both healthcare systems by referring from one system to another.

This can be associated with the Setswana expressions that say "*Mabogo dinku a thebana; Kgetsi ya tsie e kgonwa ke go tšhwaraganelwa le setšhwarwa ke ntša pedi ga se thata* " *their equivalent in English is: " unity is power; united we stand and*

divided we fall." These expressions could be motivating to initiate collaboration in handling the burden of diseases as collective healthcare professionals, especially, with consideration of the analogy of the traditional and biomedical model as illustrated in Figure 1.1.

Kaboru, Falkenberg, Ndulo, Muchimba, Solo and Faxelid (2005:13) identified positive aspects of collaboration such as protection and compensation of THPs, respect for their secrecy, improvement in THPs' qualifications and good practice in their profession, education of both THPs and modern providers and community involvement. They also reported improved system of communication, standardized practices, training, establishment of trust, establishing cooperative relationships and more collaborative networks.

In the South African context, several researchers have identified trends such as mixed attitudes and respect, control or regulation of Traditional Health Practices, training needs of healers and nurses, mutual understanding and patient referrals(Pinkoane, Greef & Koen, 2008:7; Peu, Troskie& Hattingh, 2001:26; Campbell- Hall, Peterson, Bhana, Mjadu, Hosegood & Flisher, 2010: 622; Setswe, 1999:54, Peltzer & Mngqundaniso, 2008:380).African Traditional Medicines(ATM)are playing an increasing role in the South African healthcare system and the trend is also evident in health sector reform globally (South Africa, 2008:33). van Wyk (2009:31) indicated that THPs are the frontline of PHC because they provide holistic, preventative, promotive, curative and rehabilitative health care to communities.

van Rensburg (2009:554) stated that THPs participated as supervisors for the community-based Directly Observed Treatment Strategy (DOTS) programme in Hlabisa. The programme yielded positive outcomes as follows: 86% of patients supervised by the THPs completed their treatment compared to 67% of patients supervised by others and the mortality rate was significantly lowered to 6% among patients supervised by THPs compared to 18% of those supervised by others. It was concluded that THPs made an effective contribution towards improving TB health outcomes.

According to Richter (2003:10), THPs have an influential role to play in the lives of African people and have the potential to serve as crucial components of a comprehensive healthcare strategy. Therefore there is a need to build the healthcare system of South Africa (SA) by strengthening and supporting the national response to HIV/AIDS (Richter, 2003:2; Ndhlalambi, 2009:28). Campbell- Hall et al.(2010:611) also indicated that THPs play an important role in mental health services by providing psycho social support and a culturally appropriate healthcare. The culturally appropriate healthcare is in line with Leininger's theory of Culture Care Diversity and Culture Care Universality that healthcare providers should provide culture congruent care Leininger in (George, 2002:494).

Dennil et al. (2004:184)highlighted that training programmes have been initiated by the Department of Health (DoH) for THPs. Training programmes covered topics such as HIV/AIDS, Tuberculosis (TB) and aspects of maternal and child healthcare to upgrade their skills and knowledge so as to improve healthcare practices. In Sub-Saharan Africa, the ratio of traditional practitioners to the population is approximately 1:500, while that of medical doctors to the population 1:40 000 (van Wyk, 2009:31; Robins, 2009:6). According to Elujoba, Odeleye and Ogunyemi (2009: 2),it is estimated that 80% of patients in Africa visit THPs before consulting with conventional medical practitioners here referred to as Community Nurses (CNs).According to Kaboru, Falkenberg, Ndubani, Hojer, Vongo, Brugha and Faxelid (2006:16), THPs and Biomedical health practitioners seemed willing to strengthen collaboration with each other in the struggle against HIV/AIDS.

Ndhlalambi (*2009*:38) and Robins (2009:6) revealed that the THPs provides a valued and trusted PHC services and that over 60% of rural inhabitants in South Africa seek healthcare advice and treatment from THPs before visiting a mainstream PHC services. This statement is an indication that SA is practicing pluralistic healthcare system.

In South Africa there is an estimation of 200 000 THPs, compared to 25 000 conventional medical doctors (van Wyk, 2009:31; Ndhlalambi, 2009:32).This means that THPs are 175 000 more than the conventional medical doctors and the implication is that the conventional medical doctors cannot carry the healthcare

workload alone and; therefore, it is imperative that the available, accessible and affordable healthcare resource should be utilized by the communities for their health problems. The 2011 South African Nursing Council (SANC) nursing manpower geographical distribution for North West Province is outlined in table 1.1 below http://www.sanc.co.za/stats/stat2011/Distribution%202011xls.htm (accessed on 3/18/2011).

Table 1.1: SANC Nursing Manpower as at2011/12/31 for North West Province

Gender	Professional Nurses (PNs)	Staff Nurses (SNs)	Auxiliary Nurses (ANs)	Total
Females	7094	2444	4249	13787
Males	884	247	582	1713
Total	**7978**	**2691**	**4831**	**15500**

Professional Nurses accounted for the majority of nursing manpower, followed by the Auxiliary Nurses.

In developing a model of successful HIV/AIDS intervention, African Medical Research and Foundation (AMREF) in SA identified a model of best practice emerging from a successful collaboration between a traditional healers' forum and a PHC programme in Standerton, Mpumalanga Province. The THPs were deployed at Standerton hospital to offer counseling and HIV prevention (Ndhlalambi,2009:38). The outcome of Umkhanyakunde district in KwaZulu-Natal Province, Traditional healers' project revealed that THPs who had undergone practical training and participated in strengthening of community based patient management and referral system had significantly contributed to the early detection of diseases such as HIV/ AIDS and Tuberculosis (TB) and the project had been a success (Ndhlalambi, 2009:54).

The Constitution of the Republic of South Africa (1996:13) section 27 (1) outlines that everyone has the right to healthcare services. This section is understood to embrace all healthcare services including the traditional healthcare services. It is

therefore the responsibility of the government to ensure that people have access to these facilities and that their safety and well-being is guaranteed. People also have freedom of choice which embraces the healthcare services they utilize (van Wyk, 2009: 66). Complimentary to freedom of choice is the patients' right charter that allows clients to choose which healthcare service to consult for health problems.

Although traditional healing is still mostly being practiced outside the boundaries of state control, there is to some extent a legalized plural medical system in SA and is guided by the Traditional Health Practitioners Act 22 of 2007. Traditional health practice in South Africa has now been legalized and recognized (van Wyk, 2009:49; NDoH, 2008:1; Truter, 2007:56 ; Dinat, 2009 : 11; Shuster, Sterk, Frew, & del Rio, 2009: 22).

Despite the fact that Traditional Health Practice has been legalized, the reality on the ground will not change dramatically; consequently open dialogue, mutual understanding and willingness to cooperate will not appear overnight (van Wyk, 2009:49). There are still a few misconceptions in collaboration between traditional health and the orthodox health practitioners. At the grassroot level and within the community, collaboration between THPs and CNs is essential for the elimination of stereotypes and prejudices about the traditional health practices. For effective healthcare at this level, it is important that there is professional cohesion and collaboration between the CNs and THPs.

It is however, worth noting that it seems like inter-professional collaboration between THPs and CNs is not being realized at operational level, hence the researcher was interested in investigating this inter-professional collaboration. vanRensburg (2009:544) states that in 1979 the Alma-Ata declaration on PHC opened the window of opportunity for traditional healing and its recognition by the Western medical practitioners. Wreford (2005:110) supports the statement by recommending that biomedical interventions acknowledges the reality of traditional healing and engage with its complexity.

1.2 Problem statement

Most Black African communities still use and will continue using the healthcare services provided by the traditional healers and the community nurses either singly or concurrently. This could be associated with the fact that traditional and biomedical medicines differ in theories on causation of disease and illness and even in management of health problems. In spite of the Alma -Ata declaration, thirty two (32) years ago, an integrative health care service is not yet achieved and this is perpetuated by burden of diseases explosive twin epidemics of HIV/AIDS and TB" whereby patients are consulting both biomedical doctors and traditional healers for all kinds of physical, emotional and spiritual health problems.

To handle the burden of diseases; it requires mobilization of existing and potential resources of the two healthcare systems, that is, the THPs and CNs for coordinated and controlled effort from the grassroots to national level. The need for inter-professional collaboration between the THPs and CNs in providing PHC is now more important and imminent to address health problems faced by communities. This indirectly affects access to healthcare services and impact adversely on overall management of acute and chronic ailments. International and national studies found that collaboration between the THPs and CNs is imperative in the provision of PHC services. As a result of this, healthcare professionals cannot ignore alternative methods of healthcare as this will reduce their capacity to provide service to their patients.

The South African government, through the National Department of Health (NDoH), made interventions towards the official recognition, institutionalization and empowerment of African Traditional Medicine (ATM) through the following:

-the National Drug policy (1996) that recognizes, the potential role and benefits of available remedies of ATM in the national health system and the potential role of traditional healers in the formal healthcare sector,

-the Directorate: The Traditional Medicine, a new directorate that was established to manage the work related to Traditional Medicine within the Department of Health, this has also been extended to the Provincial

Departments of Health,

-Traditional Health Practitioners Act, Act 22 of 2007 which was endorsed in January 2008. This Act provides for the legal recognition of traditional medicine in South Africa as part of the wider healthcare system,and

- draft policy on ATM for South Africa (2008:13) for the institutionalization of ATM.

Despite this major breakthrough, the researcher has observed that very little has changed at the level of healthcare service delivery with the result that, a rich resource of healthcare may remain largely untapped; in particular THPs. In the North West Province (NWP) there is limited empirical evidence about the nature and extent of inter-professional collaboration between the THPs and CNs; In view of this the proposed study, aims to investigate the nature and extent of inter-professional collaboration between the THPs and CNs in the Ngaka Modiri Molema (NMM) district.

1.3 Purpose of the study

The purpose of this study was to investigate and describe the nature and extent of inter-professional collaboration between the THPs and the CNs in Primary Health Care (PHC) in the NMM district of the NWP of South Africa.

1.4 Specific objectives of the study

The specific objectives were to investigate:

1.4.1. The specific elements of collaboration such as respect, trust, and mutual understanding in inter-professional collaboration,

1.4.2. The attitudes of both THPs and CNs in collaboration,

and to:

1.4.3. Describe the referral systems between THPs and CNs and

1.4.4. Identify factors that support inter-professional collaboration between the THPs and CNs in PHC.

1.5 Significance of the study

It is hoped that the results of the study will assist in developing strategies or models towards strengthening inter-professional collaboration between the THPs and CNs in PHC. Furthermore, the outcome of this study will be beneficial in different ways to different stakeholders:

- **Department of Health and Policy makers:** It is envisaged that the findings will be useful in guiding policy makers and other stakeholders in the development of guidelines and management of collaboration between the THPs and CNs.
- **Curriculum developers and Nursing Education Institutions (NEIs):** The findings will be useful in the development of curriculum for Nursing Education Institutions to align with current developments in healthcare practices and indigenous knowledge systems.
- **Improvement in healthcare practice:** Integration and healthcare practice maybe improved in terms of reduction in morbidity and mortality rates thereby lowering the burden of diseases that impacts on life expectancy.
- **Workshops on the outcome of this study: It** is also envisaged that workshops on the outcome of this study might assist in the reduction of prejudices and stereotypy between both healthcare professionals.

1.6 Definition of concepts

1.6.1 Inter-Professional Collaboration (IPC)

Inter-professional collaboration refers to members of different healthcare professions working together to provide service based on knowledge, expertise, respect and joint contribution to a common goal (Martin, Ummenhofer, Manser & Spirig, 2010:2; Alberto & Herth, 2009:2; WHO, 2010:13; Broers, Poth & Medves, 2009:4).

Operational definition of Inter-Professional Collaboration (IPC)

In the context of this study Inter-professional collaboration refers to a process whereby THPs and CNs are acknowledging each others' healthcare expertise through mutual respect, positive accommodating attitudes, mutual referral and

support to each other with the aim of providing legitimate, congruent and acceptable healthcare services to individuals and communities.

1.6.2 HealthCare Professionals (HCPs)

HealthCare Professionals refers to all people engaged in actions whose primary intent is to enhance health, promote and preserve health, diagnose and treat diseases. They are professionals with discreet or unique areas of competence whether regulated or non-regulated, conventional or complementary (WHO, 2010:13).

Operational definition of HealthCare Professionals

In the context of this study HealthCare Professionals refers to persons who have undergone for a formal or informal training with a purpose of providing healthcare services according to their scope of practice and expertise. In the context of this study; this definition includes Traditional Health Practitioners and Community Nurses.

1.6.3 Traditional Health Practice

The THPs Act (2007:6) refers to traditional health practice as performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicines or traditional practices whose objects include the:

- maintenance and restoration of physical or mental health or function; or
- diagnosis, treatment or prevention of a physical or mental illness; or
- rehabilitation of a person to enable that person to resume normal function within the family or community and
- Physical or mental preparation of individual for puberty, adulthood, pregnancy, childbirth and death.

Operational definition of Traditional Health Practice

In the context of this study, Traditional Health Practice refers to traditional healthcare performances, practices, functions, activities and rituals processes that are performed by the THPs within the context of promotive, preventative, curative and rehabilitative healthcare services and are recognized accepted by the communities.

1.6.4 Traditional Health Practitioners (THPs)

Traditional Health Practitioners refers to persons who are recognized by the community in which they live to provide healthcare by using vegetable, animal and mineral substances and certain other methods based on social, cultural and religious background, as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability (WHO, 1978:9).

The THP Act (2007:6) defines a THP as a person registered under the THP Act, Act 22 of 2007 in one or more categories of the traditional health practitioners. The Act outlines categories of THPs such as diviners, herbalists, traditional surgeons and traditional birth attendants. According to van Rensburg (2009:536) THPs do not all perform the same functions each type has its own domain and specializes in a particular area, although some roles may overlap. Each commands their own method of diagnosis, treatment and potent medicines.

Operational definition of Traditional Health Practitioners (THPs)

In the context of this study, THPs refers to persons who utilizes recognized and acceptable traditional healthcare practices or approaches and methods which focuses on promotive, preventive, curative and rehabilitative healthcare services to clients and patients. They may be registered or not registered with the Interim Traditional Health Practitioners Council according to the THP Act, Act 22 of 2007. Categories of THPs for this study includes diviners (*ngaka ya ditaola and sankoma*), herbalists, traditional surgeons and Traditional Birth Attendants (TBAs).

1.6.4.1 Types of Traditional Health Practitioners

1.6.4.1.1 Diviners (traditional doctor/ *Ngaka ya ditaola or Sankoma*)

Diviners are THPs who cast bones or use any form of divination set for divination of causes of people's complaints. They cast bones to define illness and determine the circumstances surrounding the cause of illness. Through their divination set they connect with their ancestors who give them assessment and diagnostic powers. They have skills and knowledge to reveal to their customers what their ancestors expects them to do (van Wyk, 2009:36).The majority of THPs undergo training that varies from three months to a year or more with just a few who do not undergo any training.

1.6.4.1.2 Herbalists (*Ngaka e tšhotšha*)

Herbalists are ordinary people who have acquired an extensive knowledge of medical technique and who do not typically possess occult powers (van Wyk 2009:37; van Rensburg, Fourie & Pretorius, 1994:329; van Rensburg 2009:538; Tjale & de Villiers, 2004:157).Herbalists learn their skills through apprenticeship with an expert and in the process they acquire extensive knowledge in the use of herbal medicine, curative herbs and medicinal mixture. They learn where they may dig roots and prepare medicines.

1.6.4.1.3 Traditional surgeon (*Rra thipana*)

Traditional surgeon refers to a person who performs circumcision as part of African cultural initiation ceremony (van Rensburg, 2009:537). The Traditional Health Practitioners Act, Act 22 of2007 defines the traditional surgeon as a person who is registered as a traditional surgeon under the THP Act, Act 22 of 2007 (THP Act, 2007:6).

Operational definition of traditional surgeon

In the context of this study, traditional surgeon refers to a person who performs circumcision as part of a cultural initiation process and includes any person who has been trained and meets the requirements to perform such circumcisions; and is recognized by his community.

1.6.4.1.4 Traditional Birth Attendants (TBAs)

Traditional Birth Attendants are middle aged or elderly women with no formal training, who acquired their skills through experience and attend to women during pregnancy, labor and the postnatal period in various ways. Their practices may include advice or instructions as to what to eat and what not to eat, giving herbal remedies for pain, sickness or discomfort, abdominal massages, offering comfort to mothers and giving them a sense of security. They also assist with the delivery of the baby, advice and assist the new mother on how to care for the baby after it is born (Peltzer, & Henda, 2006:140). During postnatal care, TBAs work to prevent complications and maintain good nutrition (van Wyk,2009:38).The Traditional Health Practitioners Act22 of 2007 defines the TBA as a person who engages in traditional health practice and is registered under the THP Act, Act 22 of 2007 (THP Act, 2007:6).

1.6.5 Community Nurses (CNs)

Community Nurses refers to nurses who have undergone education and training programme according to SANC regulations (R 276 of 1980 as amended; R425 of 1989 as amended) and are registered with the SANC for a qualification in Community Nursing Science (SANC, 1980:2; SANC, 1985:1).

Operational definition of Community Nurses

In the context of this study, Community Nurses refers to nurses who are registered with SANC after undergoing formal education and training at an approved Nursing Education Institution and are expected to practice according to their scope of

practice. The three categories of nurses that is Professional Nurses (PNs), Staff Nurses (SNs) and Auxiliary Nurses (ANs) will be included in this study as CNs. These are nurses who predominantly serve in fixed or mobile PHC setting and are expected to render promotive, preventive, curative and rehabilitative healthcare services according to their scope of practice. These categories may have or may not have a qualification in Community Nursing Science. The definition exclude nurses who are intending to register for the first time as professional nurses and are registered with SANC in the category community service and still perform community service.

1.6.5.1 Categories of Community Nurses (CNs)

1.6.5.1.1 Professional Nurses (PNs)

Professional Nurses refers to nurses who have undergone education and training programme for two or more years according to SANC regulations (R 683 of 1989 as amended; R425 of 1989 as amended) and are registered with the SANC (SANC, 1989:2; SANC, 1985:2). Professional Nurses are qualified and competent to independently practice comprehensive nursing in a manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (SANC, 2005:25).

Operational definition Professional Nurses

In the context of this study, Professional Nurses refers to nurses who are registered with SANC; working in a community setting predominantly serving in fixed or mobile PHC setting and are expected to render promotive, preventive, curative and rehabilitative healthcare services according to their scope of practice. They include professional nurses who have or do not have a qualification in Community Nursing Science but exclude (nurses who are intending to register for the first time as professional nurses; are registered with SANC in the category community service and still performs community service).

1.6.5.1.2 Staff Nurses (SNs)

Staff Nurses refers to nurses who have undergone two year education and training programme, according to SANC regulation (R.2175 of 1993 as amended) and are registered with the SANC (SANC, 1993:3). Staff Nurses are educated to practice basic nursing in the manner and to the level prescribed (SANC, 2005:25).

Operational definition Staff Nurses

In the context of this study, Staff Nurses refers to nurses who are registered with SANC; working in working in a community setting, predominantly serving in fixed or mobile PHC setting and are expected to render promotive, preventive, curative and rehabilitative healthcare services according to their scope of practice. They do not have a qualification in Community Nursing Science.

1.6.5.1.3 Auxiliary Nurses(ANs)

Auxiliary Nurses refers to nurses who have undergone a one year education and training programme according to SANC regulation (R.2176 of 1993 as amended) and are registered with the SANC(SANC, 1993:3).Auxiliary Nurses are educated to provide elementary nursing care in the manner and to the level prescribed (SANC, 2005:25).

Operational definition of Auxiliary Nurses

In the context of this study, Auxiliary Nurses refers to nurses who are registered with SANC; working in a community setting, predominantly serving in fixed or mobile PHC setting and are expected to render promotive, preventive, curative and rehabilitative healthcare services according to their scope of practice. They do not have a qualification in Community Nursing Science.

1.6.6 Primary Health Care (PHC)

The definition of Primary Health Care as determined at Alma-Ata is: "essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of continuing healthcare service"(WHO, 1988:15).

Dennil et al. (2007:5) highlights that Declaration seven (7) of the Alma-Ata outlines that PHC relies, at local and referral levels, on health workers and this includes physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed. These healthcare professionals must be suitably trained, socially and technically to work as a health team and to respond to the expressed health needs of the communities.

Operational definition of PHC

In the context of this study, PHC refers to promotive, preventive, curative, and rehabilitative healthcare services provided by THPs and CNs to individuals, groups and communities at a mobile or fixed clinical facility; home setting or THPs' practice setting.

1.6.7 Culture Congruent Care

Culture congruent care is defined as "those cognitively based assistive, 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 healthcare or well-being services" Leininger in (George, 2002:494).

1.7 Theoretical framework (Leininger's theory)

Leininger's theory of Culture Care Diversity and Culture Care Universality is depicted in her Sunrise Model as shown in Figure 1.2. The central theme of Leininger's theory is the concept of culture congruent care to individual, groups , communities and institutions by creatively combining the professional(scientific) and generic (traditional)healthcare systems that coexist in many societies (Tjale & de Villiers 2004:22). Culture congruent care is achieved by practicing clinical judgments and decision making to preserve, negotiate changes to, or restructure cultural practices in order to enhance the well being of clients (Tjale & de Villiers, 2004:23).

Culture Care Diversity indicates "the variabilities and or differences in meanings, patterns, values and lifeways or symbols of care within or between collectives that are related to assistive, supportive or enabling human care expressions" Leininger in (George, 2002:492). In contrast, Culture Care Universality indicates the "common, similar, or dominant uniform care meanings, patterns, values, lifeways or symbols that are manifest among many cultures and reflect assistive, supportive, facilitative or enabling ways to help peoples" Leininger in (George, 2002:492).

It is imperative that healthcare professionals understand that there are cultural differences with regard to beliefs and practices related to health, illness and care; this is in line with Leininger's theory of Culture Care Diversity and Culture Care Universality. THPs are observed to incorporate clients' cultural beliefs into health care. Healthcare professionals as providers of healthcare to persons should have the understanding that cultural values, lifeways, language and environment have strong influence on healthcare patterns and expressions as depicted in Leininger's Sunrise Model and that these dimensions should be considered during patient or client care. It is on the basis of the above that the study is based on Leininger's theory of Culture Care Diversity and Culture Care Universality.

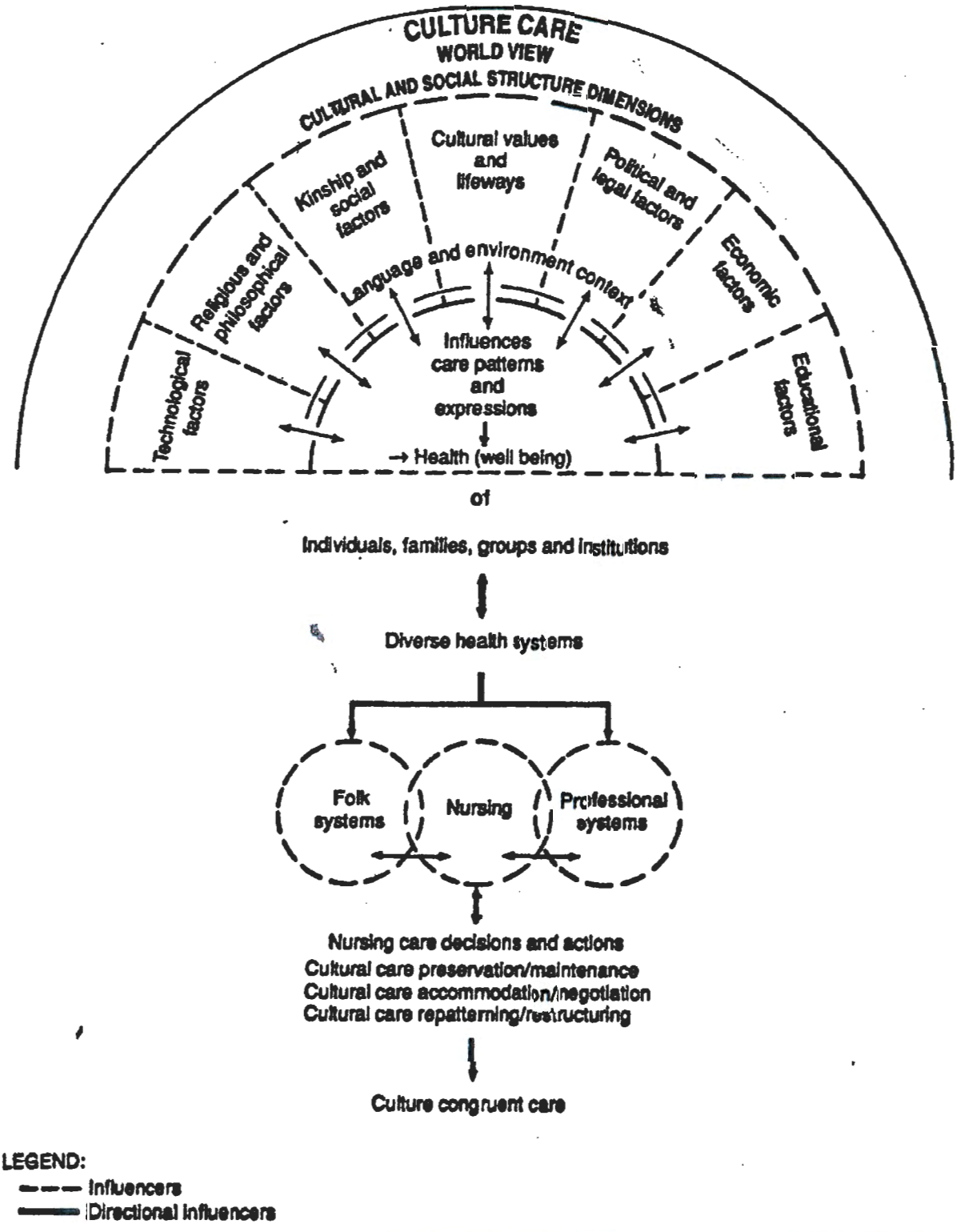

Figure 1.2: Leininger's Sunrise Model to depict theory of Culture Care Diversity and Culture Care Universality.

Source: Leininger in (George, 2002:496).

Figure 1.2 Leininger provides a guide to the inclusion of culture as a vital aspect of nursing practice. Her Sunrise Model posits that important dimensions of culture care and social structure are: technology, religion, philosophy, kinship and other related social factors, cultural values and lifeways, politics, law, economics and education within the context of language and environment. All these dimensions influence care patterns and expressions that impact on the health or wellbeing of individuals, families, groups and institutions.

The Sunrise Model also depicts diverse health systems that are overlapping or interacting to provide nursing. These health systems are the folk (traditional) and the professional (biomedical) which are congruent to the THPs and CNs as healthcare professionals in this study with diverse healthcare practices. Leininger's theory of Culture Care Diversity and Culture Care Universality has three modes of culture care which influence culture congruent care and could guide nursing care decisions and actions for both THPs and CNs. The three modes are: Culture care preservation, Culture care accommodation and Culture care restructuring. Leininger aims at alerting, supporting and informing healthcare professionals about the importance of using cultural information to understand similarities and differences in culturally congruent care as nursing care decisions and actions are made to health and caring.

The three modes of nursing care are described as:

- Culture care preservation refers to assistive, supportive, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and /or preserve relevant care values so that they can maintain their well-being, recover from illness or face handicaps and/or death Leininger in (George, 2002:494). This is important for Traditional Health Practitioners and Community Nurses to retain; maintain and preserve cultural activities that have a positive impact on well-being of clients. Healthcare professionals are to maintain those cultural practices that are harmless and incorporate them into the client's care plans. Galabuzi, Agea, Fungo and Kamoga (2010:16) highlight that useful traditional medicine practices can further be developed and promoted.

- Culture care accommodation (negotiation) refers to assistive, supportive, facilitative or enabling professional actions and decisions that help people of a designated culture to adapt to or negotiate with others for a beneficial or satisfying outcome with care providers Leininger in (George, 2002:494).This means that THPs and CNs would negotiate and adapt to cultural activities that promote health and discard those cultural activities that have negative impact on the well-being of clients especially if there is a potential that safe health care delivery could be compromised. An example is where there is a possibility of using herbal medications and prescribed medications concurrently and there is possible adverse drug interaction, healthcare professionals could negotiate with the client to suspend one of the treatments until the course of the other treatment is completed.

- Culture care re-patterning refers to assistive, supportive, facilitative or enabling professional actions and decisions that help clients, reorder, change or greatly modify their lifeways for new, different and beneficial health care patterns. While respecting clients' cultural values and beliefs and providing a lifeway more beneficial or healthier than before changes were co-established with the clients Leininger in(George, 2002:494). This means that sensitivity to clients' culture should be respected; however cultural practices that are detrimental to the health of clients should be re-looked into or modified. An example of THP giving herbal enema to a child presenting with diarrhoea could lead to severe dehydration. The THP could rather be advised to give oral fluids to prevent dehydration and refer the child to the clinic. The CNs should also commend the THP for referring the child to the clinic for further management.

Leininger's theory of Culture Care Diversity and Culture Care Universality was chosen as the framework for this study because of the following:

- Leininger's theory prepares and guides both THPs and CNs to understand that they are caring for people with cultural diversity and similarities; therefore, culture congruent care should form the basis of inter-professional collaboration;
- Both the THPs and CNs are cultural beings from diversity of cultures and are providing healthcare services to people or clients from various cultural groups;
- The Leininger's Sunrise Model depicts the folk (THPs) and Professional(CNs) as diverse health systems which are all centred on nursing;
- The THPs are observed to incorporate clients' cultural beliefs into the health care. CNs are caring for cultural beings and are expected to have the understanding that, dimensions of culture care and social structure for example e.g. religion, kinship and other related social factors, cultural values and lifeways, within the context of language and environment have influence on care patterns and expressions that impact on the health or wellbeing of individuals, families, groups and institutions and
- Both THPs and CNs provide healthcare to individuals, families, groups and communities.

1.8 Outline of the study

Chapter 1 introduces the study by outlining the background, purpose and objectives of the study.

Chapter 2 discusses literature reviewed for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 presents results and discussions

Chapter 5 concludes the study, discusses limitations and recommendations.

1.9 Summary

This chapter introduced the topic: "Investigation of inter-professional collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the Ngaka Modiri Molema district in the North West Province (NWP)." The background of the study was discussed, including the problem statement, purpose, and specific objectives, significance of the study and the key concepts were defined. Theoretical framework of the study and the outline of the study were described.

CHAPTER 2

2 Literature review

2.1 Introduction

This chapter discusses literature review undertaken on inter-professional collaboration between the Traditional Health Practitioners (THPs) and Community Nurses (CNs). The purpose of the reviewed literature was to present an overview of what is already known about the inter-professional collaboration between the THPs and CNs in PHC. Literature employed in this study was obtained from the following search engines: Science Direct, EBSCO, SA ePublication, IEEE Xplore, Digital Library and J Store. The key concepts and related elements of the topic were identified and more information was searched. Literature reviewed provided a handy guide to the topic under study.

Mouton (2001:86) indicated that it is essential that every research project begins with the existing literature as it forms an essential component of any study. Reviewing literature has assisted the researcher in the following:

- Discovering the most recent and authoritative theorizing about the study topic,
- Finding out what the most widely accepted empirical findings in the field of study are,
- Ascertaining what the most widely accepted definitions of key concepts in the field are, common themes and items and
- Identifying gaps, limitations and recommendations by other researchers.

Procedure for review of literature: The topic of interest was highlighted and the key concepts were outlined. Information was sourced from the academic library books, International and National journals, grey literature and through the internet. Information was sourced from various sources especially with the guide of the abstract.

In this study literature was reviewed under the following sub-headings:

2.1.1 Inter-professional collaboration,
2.1.2 Elements of Inter-professional collaboration,
2.1.3 Legislative framework for traditional healers and
2.1.4 Barriers to inter-professional collaboration.

2.2 Inter-professional Collaboration (IPC)

Inter-professional collaboration refers to members of different healthcare professions working together to provide service based on knowledge, expertise, respect and joint contribution to a common goal (Martin, Ummenhofer, Manser & Spirig, 2010:2; Alberto & Herth, 2009:2; WHO, 2010:13; Broers, Poth & Medves,2009:4; Troskie,1997:36). Troskie (1997:36) further explains that inter-professional collaboration is also a process whereby conflicting parties are brought into harmony with each other and supports one another.

Kaboru et al. (2006:2) refers to inter-professional collaboration as increased dialogue and communication between the two health sectors as well as various joint activities aimed at improving patient care and support. The benefits of inter-professional collaboration as stated by Martin et al. (2010: 2)are: inter professional education and improved patient outcomes.

Naylor (2011:12) argued that there is no question that IPC improves quality of care. Smadu (2008:190) suggested a patient centred collaborative model which requires negotiation, non competitive and non- hierarchical approach to patient care. Strengths, weaknesses, challenges, generalization and limitations of the reviewed literature on inter-professional collaboration between the THPs and CNs will be highlighted as follows:

- Most of the researchers highlighted the importance of acknowledging the expertise of both the THPs and CNs and the different roles played by each other. Naylor (2011:2) found that where the nurses collaborated as equals

with other healthcare providers, patient outcomes and quality of care improved.

- The following elements of inter-professional collaboration were elicited from most of the reviewed literature: mutual respect, mutual understanding, trust, attitude, mutual referral and support.

- Most of the findings in the literature on inter-professional collaboration are not outlining at least how collaboration should be structured. There is also no clear inter-professional collaboration model. Most researchers mentioned elements of collaboration such as mutual respect, mutual understanding, trust, attitude and mutual or cross referral. Therefore lack of clear and specific guidelines on collaboration was observed.

- There are many concepts used for Healthcare Professionals in the Western healthcare system nationally and internationally. The following are among the commonly used concepts in various literatures: (Biomedical Health Practitioners, Biomedical Health Professionals, Western medicines, Allopathic, Orthodox, Formal healthcare Professionals, Community Nurses). For the purpose of this research the concept Community Nurses (CNs) was used. Conversely the following concepts were commonly used for the THPs: (Traditional healers, folk medicines, African Traditional Medicine).For the purpose of this research the concept Traditional Health Practitioners (THPs) was used. The Western health professionals have a superiority, undermining, hierarchical complex towards the THPs and that may impact negatively on collaborative efforts.

- Inter-professional collaboration is naively oversimplified and that there are many differences between the two approaches to healthcare. Most of the research findings indicate the willingness of the two healthcare professionals advocating for inter-professional collaboration especially the THPs. Research findings advocate for patient centred collaborative approach.

- Limited information on the South African situation was observed. Most of the reviewed literature does not indicate the views of the health professionals' controlling bodies such as the South African Nursing Council and other health professional councils regarding the inter- professional collaboration between the formal health professional and traditional health practitioners.

2.3 Elements of Inter-professional Collaboration

Smadu (2008:190); Martin et al. (2010:2) and Alberto & Herth (2009:5) highlighted that mutual respect, mutual understanding and trust are essential elements of inter-professional collaboration. Madiba (2010:221) identified attitude as another element of collaboration. Referral system and support to collaboration were included as elements of inter- professional collaboration. The under-listed themes appeared in most of the literature reviewed on inter-professional collaboration and will be discussed as elements of inter-professional collaboration. The themes and sources are listed below:

- **Mutual respect, mutual understanding and trust**: (Oxford South African SchoolDictionary,2010:599;Purden,2005:229;Wyk,2005:15;Madiba,2010:222; Dinat,2009:12;Wreford, 2005:59; Kayomboet al.,2007:3; Vaka et al., 2009:94; Campbell-Hall et al., 2010:623; Troskie, 1997:38; Tjale & deVilliers ,2004;10; Pinkoaneetal.,2008:7; WHO,2010:29;Peltzer & Mngqundaniso, 2008:385; Madiba,2010: 222; Broers et al.,2009:4 ;Smadu, 2008:198).

- **Attitudes**: (Oxford South African School Dictionary,2010:599; Tjale & de Villiers,2004;121; Peu et al., 2001:26; van Rensburg,2009:552; Peltzer &Mngqundaniso,2008:383; Ndahlalambi,2009:52; Madiba,2010:224; Troskie, 1997:34).

- **Referral system**: (Campbell-Hall et al. ,2010:619; Peltzer et al.,2006:4; Peltzer & Mngqundaniso, 2008:381; Meissner, 2004:14;Kaboru et

al.,2006:7;Madiba,2010:223; Mhame,2010: 46;Bowa, Jumbo & Wolf , 2003:11;van Rensburg,2009:553; Peltzer, Khoza, Lekhuleni, Madu, Cherian & Cherian Tjale & de Villiers, 2004:6; van Deventer, 2004: 28; Kaboru et al., 2005:7; UNAIDS, 2000:34; Tembani, 2009:220;Mhame et al.,2010:46;Ndahlalambi,2009:52; Peltzer,2009:957; Pinkoane et al.,2008:7; Peu et al., 2001:26; Peltzer & Mngqundaniso,2008:383; van Wyk, 2009:37; Troskie,1997:34).

- **Support to collaboration:** Oxford South African School Dictionary,2010:599; Dheyongera,1994:16; Makoa,2000:83; Pinkoane et al.,2008:8; Kaboru et al.,2005:2; Vaka et al.,2009:94; Peu et al., 2001:53;Mhame et al.,2010: 45; Peu et al., 2001:54;van Dyk 2001:9;Dennilet al.,2007:184;Peltzer et al., 2006:34;ANC,1994:55; van Wyk,2005:15; WHO,2010:14).

2.3.1 Mutual respect, mutual understanding and trust

2.3.1.1 Mutual Respect

Respect refers to being polite to somebody or something to have good opinion of somebody or something (Oxford South African school dictionary, 2010:509). Troskie (1997:40) indicated that it is important and necessary to show respect and have a positive attitude towards THPs. This view concurs with that of Purden (2005:229) who indicated that respect is one of the key elements to successful collaborative relationships between and among the professionals. An integrated healthcare system requires flexibility in order to accommodate the skills and varying levels of knowledge of all practitioners through mutual respect and recognition of the contributions that all role players make (van Wyk, 2005:15).

Madiba (2010:222) and Dinat (2009:12) stated that one of the key elements to a successful inter-professional collaboration is building mutual respect through dialogue and consistent exchange of information and eagerness to learn from one another. Wreford (2005:59); Kayombo et al. (2007:3) and Vaka et al. (2009:94) have the same undertaking that mutual respect is important for successful dialogue and

engagements. Wreford (2005: 59) further stated that THPs are generally interested in the idea of partnership and association with the biomedical healthcare professionals however their enthusiasm is rarely reciprocated. The statement could be attributed to lack of mutual respect because mutual respect creates an opportunity for dialogue, discussions and deliberations on issues that are affecting the parties concerned.

Purden (2005:224) highlighted that mutual respect should be fundamental to the delivery of culturally competent healthcare to all ethnic communities. Campbell-Hall et al. (2010:623) have the similar view that in order to build mutual respect; Western healthcare should focus on care approach which is accommodative of diverse cultural explanations of illnesses. These views are in line with Leininger's theory of culture care diversity and culture care universality where she outlines three culture care modes. Culture care accommodation (negotiation) mode refers to assistive, supportive, facilitative or enabling professional actions and decisions that help people of a designated culture to adapt to or negotiate with others for a beneficial or satisfying outcome with care providers.

Most researchers are of the view that mutual respect is an important element of collaboration as it forms the basis for dialogue for the THPs and CNs. It is through dialogue and discussions were similarities, differences, complementaries, myths, challenges and uncertainties can be identified and strategies be employed to handle such discussions outcomes and healthcare approaches.

2.3.1.2 Mutual understanding

It is important that the concept inter-professional collaboration should be mutually understood by both the THPs and CNs. Broers et al. (2009:4) highlighted that a shared understanding of inter-professional collaboration across the healthcare professionals is critical for effective collaboration to occur. Troskie (1997:38) highlighted that the concept does not imply a superior or subordinate relationship, but rather that, of a supportive role, acknowledging others' field of expertise and improved patient outcomes. She is of the view that successful collaboration depends

on the participants' understanding of individual roles in the process of inter-professional collaboration. The responsibilities and expectations of both the THPs and CNs should be clearly spelled out.

Tjale and de Villiers (2004:10) highlighted that multiculturalism encourages health practitioners to understand and acknowledge other cultures and traditional practices within the socio-cultural context. The implications of culture and health issues need to be recognized by healthcare professionals. This can be associated with Leininger's theory on Culture Care Diversity and Culture Care Universality which aim at rendering a culture congruent care to individuals by creatively combining the professional and traditional healthcare systems that coexist in many societies (Tjale & de Villiers, 2004:22).

Pinkoane et al. (2008:7) found that there is a need to engage both THPs and CNs to mutually understand each others worlds and work so that relationships can be forged. A similar view is shared by Vaka et al. (2009:94); Purden (2005:228) and WHO (2010:29) as they stated that creating a dialogue between THPs and nursing staff may be very useful to form a basis for understanding each other's perspective and professional role, potential contribution that each can make, common grounds that exist between them and any boundaries that need to be respected.

Peltzer and Mngqundaniso (2008:385) concluded that there is still more to be done between the THPs and CNs to enhance collaboration and improve understanding of each other's approach to patient management. They further recommended that THPs and CNs should interact to clarify misconceptions and myths related to each profession. Vaka et al. (2009:94)also emphasize that there is a need to work synergically rather than aiming at assimilation of either healthcare approach by the other. The goal should be geared towards the clients' well-being.

It is important that the two healthcare professionals meet to lay a foundation for discussion and demystify traditional healing methods. It is also worth noting that the THPs and CNs should understand that each healthcare system has a potential contribution towards the wellbeing of patients. Personal interests or personal

agendas are secondary to the shared goals of the collaborators. It is also worth noting that creating and opening dialogue for mutual understanding between the THPs and CNs will not happen overnight and that it needs patience from both healthcare professionals.

2.3.1.3 Trust

Trust refers to the belief that somebody is honest and good and will not hurt you in any way (Oxford South African school dictionary 2010:363). Madiba (2010:224) found that the majority of Biomedical Health Practitioners (BHPs) were in favor of collaboration with the THPs; however, they did not trust traditional medicine and would only collaborate for the sake of patients. Mngqundaniso and Peltzer (2008:385) highlighted that the lack of trust between the THPs and CNs could hinder the progress in patient care and they further indicated that it is important that the THPs and CNs should understand each other in order to trust one another.

Kaboru et al.(2006:7) concluded that Biomedical Health Practitioners' lack of trust in THPs was one of the major obstacles that justified their fear of not openly referring patients to the THPs. Troskie (1997:36) indicated that people should be given opportunity to express their feelings and that their identity would be secured and not be overwhelmed by the other party. These aspects would promote trust building.

Madiba (2010:222) found that CNs still had negative opinions of the traditional health practice that THPs were quacks who deceived people and that the law should be used to stop traditional health practice. Kayombo et al. (2007:8) stated that initiating inter-professional collaboration between the THPs and CNs is not as easy as reflected in the literature; therefore, cultivating trust involves a process that may take years. Troskie (1997:39) highlighted that trust building is important and results when the two healthcare professionals feel that their identity will be secured and they will not be overwhelmed by each other.

Smadu (2008:198) indicated that mutual trust, respect and understanding each others' role and expertise are essential elements of IPC. Broers et al. (2009:4)

highlighted that different professions should work together towards a common goal for optimal or improved patient care using the skills or expertise of other professions. Most researchers are of the view that mutual respect is the key element for inter-professional collaboration because it creates an opportunity for people to discuss similarities, differences, complementaries and challenges of their healthcare approaches.

The literature does not unpack concepts like mutual respect, mutual understanding and trust in view of practicality of inter-professional collaboration. Issues of respect and trust still need to be unpacked and analyzed from a practical point of view in collaboration.

2.3.2 Attitude

Attitude refers to the way a person thinks or feels about something (Oxford South African School Dictionary, 2010:39). According to Tjale and de Villiers (2004:121) attitude is viewed as learnt tendency to respond in a consistent manner. Attitudes are precursors to our behavior; refer to our likes and dislikes of situations, group, ideas and policies and the way in which people behave toward these. Each group's attitude towards the same stimuli may vary. In the context of this study, attitude refers to how the THPs and CNs react, feel, think and view aspects related to inter-professional collaboration in the context of providing PHC to communities.

Peu et al. (2001:26) revealed that nurses showed mixed attitudes, though a positive attitude towards working with traditional healers emerged high, however the inter-professional collaboration would remain unequal in relation to professional attainment, ethical-legal adherence and practices. Attitudes on consultation, referral system and cooperation were outlined perspectives .e.g. negative attitude during consultation and referral needs to be changed by the CNs.

A respectful attitude of open exchange of ideas and information can win trust and cooperation between the THPs and CNs. van Rensburg (2009:552) and Peltzer and Mngqundaniso (2008:381) reported that many BHPs were still skeptical in respect of those aspects of traditional practice that had not been subjected to scientific

investigation and they also viewed medicines used by THPs to be physiologically harmful. Bio-medical health practitioners are accustomed to their position of professional dominance and control and will not easily relinquish this status feeling of superiority. The statement supports what Peltzer and Mngundaniso (2008:382) and Ndhlalambi (2009:52) found that most of the THPs felt that they were being undermined by the nursing staff and some nurses did acknowledge that they were undermining the THPs. Madiba (2010: 224) revealed that CNs were less willing to learn traditional medicine skills and often dominate the collaborative process. This statement is indicative of negative and undermining attitude by CNs.

On the other hand, some THPs have also been equally skeptical fearing for among other aspects: threat to their cultural heritage, potential humiliation and intellectual property rights. Tjale and de Villiers (2004:10) highlighted that multiculturalism encouraged healthcare practitioners to understand and acknowledge other cultures and traditional practices within the socio-cultural context. It is therefore important that implications of culture and health issues need to be recognized by healthcare professionals. This can be associated with Leininger's theory on Culture Care Diversity and Culture Care Universality which aims at rendering a culture congruent care to individuals by creatively combining the professional and traditional healthcare systems that coexist in many societies to provide a culturally congruent care (Tjale and de Villiers, 2004:22).

Troskie (1997:34) highlighted that in areas where collaboration had already started; a positive attitude towards THPs had developed as the advantages had become clear. van Rensburg (2009:553) highlighted that research on attitudes towards formal co-operation between THPs and BHPs indicated positive attitudes with some reservations.

Literature only indicates that there is dominancy attitude of the BHPs over the THPs and derneaning of their traditional healthcare services as being unscientific. It therefore, becomes important that CNs should come closer to THPs to learn or have an understanding of each other's approach to healthcare so that both teams could align their healthcare services taking into cognizance, Leiningers' culture care modes

that is, culture care preservation, culture care accommodation and culture care re-patterning.

The reviewed literature did not emphasize that the two healthcare professionals are providing services that are more or less analogous to each other; hence, it is not possible to ignore challenging the CNs to work on their attitude to facilitate collaborative efforts.

The literature does not unpack concept such as attitude in view of practicality of inter-professional collaboration. It is important not to theorize the concept attitude but there is a need to unpacked and analyze it from a practical point of view in collaboration between the THPs and CNs.

2.3.3 Referral systems

There are various referral systems as depicted from literature review, and they are: one-way referral and two-way (reciprocal, cross, mutual) referral systems.

2.3.3.1 One way referral system

This type of referral happens when a professional person refers to another, commonly THPs referring to CNs. Campbell-Hall et al. (2010:619) revealed that health workers reported that they did not prevent mental health patients from consulting THPs, but they are not in favor of referring patients to THPs. A study conducted by Campbell-Hall et al. (2010:622); Ndhlalambi (2009:52) and Peltzer, Mngqundaniso and Petros (2006:4) revealed that THPs have never received any feedback from the Western healthcare professionals about the patients they referred to the clinics.

Peltzer and Mngqundaniso (2008:383) reported that a traditional healer in his late forties said: "we traditional healers do refer patients to clinics or hospitals, but the nurses never refer patients to us, those patients whom they can't help should be referred to us as we have a gift of curing even what has been declared incurable with western medicine. We are prepared to work hand in hand with them." Additionally

Peltzer et al. (2006:5) indicated that common conditions referred by THPs to clinics or hospitals were TB, body weakness, HIV/AIDS.

This scenario accounts for one-way referral system; however, there is a need to improve modes and mechanisms of referral. Some of the reasons elicited for one- way referral were as follows:

- modern physicians aired their objection and reluctance to refer to THPs because THPs fails to acknowledge the limits of their skills and competence (Meissner, 2004:14),
- Biomedical Health Practitioners' lack of trust in THPs is one of the major obstacles that justify their fear of not openly referring patients to the THPs (Kaboru et al,2006:7),
- concerns with toxicities, morbidities and mortalities resulting from traditional medicines (Madiba, 2010:223). A question arises from this statement, "Are there no incidences of toxicities, morbidities and mortalities resulting from Western medicines?",
- lack of referral guidelines (Madiba, 2010:223),
- CNs are not yet officially authorized to refer to THPs (Peltzer & Mngqundaniso, 2008:383) and
- THPs felt that CNs are undermining their work (Peltzer & Mngqundaniso, 2008:385).

2.3.3.2 Two-way / mutual, reciprocal, cross referral system

Mhame et al. (2010:46) stresses complementaries of both systems by referral from one health system to another. Cross-referral system between two professionals, that is, CNs and THPs is an important element of collaboration.

Bowa, Jumbe and Wolf (2003: 11) highlighted that biomedical experts agreed for a cross referral system between the traditional and medical systems. They suggested that a proper referral procedure should be introduced and both groups should agree to jointly develop a referral card that could be applicable for all illnesses including

HIV/AIDS. Kaboru et al. (2006:16) reveal that 4% of BHPs reported to have referred patients to THPs and 53% THPs reported having referred patients to BHPs.

There is a need to strengthen the referral systems between the THPs and CNs. In order to make this possible, UNAIDS (2006:14) outlined activities on creating a cross-referral system as: agreeing on referral criteria, designing referral forms and creating a follow up system. According to van Rensburg (2009:553) Medical Association of South Africa (MASA) began to consider cooperation with the Traditional healthcare system and formulated guidelines for mutual referrals. It seems these guidelines did not reach the healthcare providers at the grassroot level

Peltzer, Khoza, Lekhuleni, Madu, Cherian and Cherian (2001:46) revealed that THPs had no problems to refer to CNs as compared to CNs who seemed not to be prepared to refer to THPs. A study conducted by Peu, Troskie and Hattingh (2001:53) revealed that 90, 5% of CNs agreed that THPs should be encouraged to refer patients to the clinics immediately after consulting the THPs. This is an indication that CNs are advocating for one-way referral only which could impact negatively on collaboration.

Muller in (Tjale and de Villiers 2004:6)stated that clients would benefit from the applicable referral if there were effective interactions between the two healthcare systems. If the limits of either of the THPs or Western healthcare practices have been reached, there is a need for referral. According to Peltzer (2009:957), the Department of Health is currently not supporting referrals from the formal health sector to traditional health practitioners. He further stated that there has not been much enthusiasm in integrating the two healthcare systems in a manner that allows cross- referral and joint care. This could be attributed to the fact that there are no referral guidelines and framework between the THPs and CNs.

Pinkoane et al. (2008:7) highlighted that discussions should focus on how best the reciprocal referral system between the THPs and CNs can be realized. It should not only be THPs who refer to the CNs, but the CNs should also refer if there is a need to refer to THPs. Other researchers support the above citation by stating that

effective interaction between the two healthcare systems would benefit clients from applicable referral systems. Where healthcare limits of other systems have been reached or exhausted, the patient would then be referred to the next level of care as there is no perfect healthcare system (Tjale& de Villiers, 2004:6; van Deventer, 2004: 28; Kaboru et al., 2005:7; UNAIDS, 2000:34&Tembani, 2009:220). Mhame et al. (2010:46) concluded that any successful collaboration involves stressing complementaries of both systems by referring from one health system to another.

Peltzer et al. (2006:689) revealed that referrals to and from other THPs were more common and were above 50% than referral from and to BHPs. However THPs were highly prepared to refer patients to BHPs and work with them. van Wyk (2009:37) stated that there were different areas of specialization among the THPs, including, for example children's disease and women's fertility which also accounted for referrals which were usually through the healers themselves or through word of mouth. Troskie (1997:34) indicated that *sankomas* could even refer a patient to a herbalist for medication.

It is very clear that most findings revealed one-way referral system which is commonly from the THPs to CNs. Reasons for one-way referral have been highlighted therefore strategies must be put in place to address the reasons cited so that a two-way referral system can be encouraged and advocated for if a need arises. It is also encouraging to realize that there is referral among THPs.
There is evidence that the referral system that is dominating is one-way referral wherein, only the THPs are referring to the Western health practitioners. The principles of referral should be based on the need to refer to another level if there is no improvement in the health problem of clients and should not be based on dominancy.

Most research findings are not indicating any referral guidelines therefore, there is a need that relevant stakeholders including healthcare professionals should be involved at the grassroot level to participate in formulation of referral guidelines to promote buying in of formulated guidelines.

2.3.4 Support to collaboration

Support refers to strength, help or encouragement that is given to someone or something (Oxford South African School Dictionary, 2010:599). Makoa (2000:97) describes support as related to training of THPs and having meetings with them.
In the context of this study, support refers to embracing any positive effort(s) which is (are)geared towards facilitating, assisting, strengthening and encouraging inter-professional collaboration between the THPs and CNs to improve the wellbeing of individuals, families and communities.

Successful integration of THPs into healthcare systems needs support from all levels of department and communities. Dheyongera (1994:16) states that the strategic importance of THPs and the extent to which it is practiced in the developing countries should not be ignored by those involved in the strategic planning and development of health care systems. Makoa (2000:83) highlighted that countries like Ghana, Uganda and Valley Trust in KwaZulu-Natal had succeeded in giving support during collaboration with the THPs.

Pinkoane et al. (2008:8) and Kaboru et al. (2005:2) identified necessary themes to be formulated and regulated in order to effect policy incorporation to support inter-professional collaboration. Vaka et al. (2009:94) highlighted that it was important to create opportunities for dialogue between healthcare professionals to assist in building a basis for collaboration and understanding each others perspectives .This might create an opportunity for supporting each other because healthcare professionals would be having a better understanding of each others' approach to health care delivery. This would also assist in exploring ways of working synergically rather aiming at assimilating either approach by the other.

THPs should be empowered with the skills of needs identification, diagnosis and management of clients. Training for THPs is important to enable them to identify complications and health problems that are above their scope of practice. Inter-professional mutual education and training in standard setting would form baselines, guidelines and framework regarding healthcare practices (Peu et al., 2001: 53).

Mhame et al. (2010:45) observed that it appears that education programs can improve the THPs general knowledge and ability to counsel clients. They further indicated that better interventions need to be developed to change risk practices and encourage THPs to work with BHPs. Meissner (2004:901) revealed that many THPs were keen to learn more about modern medicine and were willing to undergo some training in order to improve their healing skills, even though some THPs were not willing to undergo training. Dennil et al. (2007:183) support Meissner (2004:901) that it is important to upgrade the knowledge and skills of THPs and to educate the community regarding their role.

Peu et al. (2001:54) recommended that CNs should conduct in-service education and workshops which would give THPs the opportunity to participate in health education programs that would I enable them to educate their clients. Similarly training programmes for THPs have been developed by the National Department of Health; some aspects covered are rehydration programmes, HIV/AIDS and Maternal and child health care (van Dyk, 2001: 9; Dennil et al., 2007:184).

Peltzer et al. (2006:34) reported that they implemented and evaluated an HIV/STI prevention and care program for THPs in rural and urban areas of KwaZulu - Natal. The results were that there was significant improvement in the HIV/AIDS knowledge and STI management strategies, risk assessment behavior, risk deduction, counseling, condom distribution, community education and record keeping by THPs. The conclusion was that THPs improved and retained their knowledge of HIV/AIDS, STIs and TB; seven (7) to nine (9) months after training and reduced their HIV risk practices. THPs contributions could further be strengthened by involving them in future HIV/AIDS programs.

The ANC (1994:55)and Pinkoane et al. (2008:10) stated that mutual education between the two healthcare systems will take place so that all practitioners can be enriched in their health practices or therapies. The statement is supported by van Wyk (2005:15) when she highlights that retraining of THPs to complement Western medicine as well as retraining of Western practitioners to understand ways in which traditional healing can contribute to holistic care is necessary.

Building a regional network to support Inter-professional collaboration could make it possible for all Inter-professional projects to share best practices, challenges and opportunities (WHO, 2010:14). Inter-professional education has potential outcome of improved attitudes towards other healthcare professionals and can also improve communication among healthcare professionals (WHO, 2010:27). The reviewed literature highlights the importance of improving the skills and knowledge of THPs HIV/AIDS, STIs and TB .This is appreciated even though training is only focusing on the THPs. There is no reciprocal learning because literature does not provide any evidence of CNs having been trained on the principles and practice of traditional medicines. The statement supports what Wreford (2005:59) found in her study that, there was less or no reciprocal learning especially from the Western medicines. There are no guidelines towards ensuring mutual education as stipulated in the National Health Plan (ANC, 1994:55).

2.4 Legislative framework on THPs and CNs

The White Paper for the Transformation of health system in South Africa(1997:57) highlights that the regulation and control of THPs should be investigated for their legal empowerment before they form part of the public health service; however, they should be recognized as an important component of the broader PHC team.

The National Department of Health (NDoH) has undertaken a move to officially recognize THPs as part of healthcare system as enshrined in the National Health Plan (ANC, 1994: 55). Baumann (2007:44) indicated that it is recognized that, the THPs play a significant role in healthcare provision in South Africa, and the move to recognize and regulate them officially has gained a momentum in recent years.

In South Africa, the government, through the NDoH, made interventions towards the official recognition, institutionalization and empowerment of African Traditional Medicine (ATM) through the following:

- The National Drug policy (1996) that recognises, the potential role and benefits of available remedies of ATM in the national health system and the potential role of traditional healer in the formal health care sector.
- The Directorate: Traditional Medicine a new directorate that was established to manage the work related to Traditional Medicine within the Department of Health, this has also been extended to the Provincial Departments of Health.
- The Traditional Health Practitioners Act, Act 22 of 2007 which was endorsed in January 2008. This Act provides for the legal recognition of traditional medicine in South Africa as part of the wider healthcare system. The purpose of the Traditional Health Practitioners Act is to:
    - Establish the Interim Traditional Health Practitioners' Council of South Africa whose objective is to ensure quality of health services within the traditional health services; in the interest of the public to promote and regulate liaison between THPs and other health professionals registered under any law (THPs Act, Act 22 of 2007:8). The liaison with other health professionals registered under any law will include the CNs,
    - Provide for the registration, training and practices of traditional practitioners, and
    - Serve and protect the interests of members of the public who use the services of the THPs (THPs Act, Act 22 of 2007:8).

- Draft policy on ATM for South Africa(2008:13) for the institutionalization of ATM is premised on the following :
    - The World Health Organization (WHO),the African Union (AU) as well as Southern African Development Community (SADC) have passed resolutions and recommendations, which urge member states to implement national policies and regulations on Traditional medicines. SA is a member of the AU and SADC and therefore has adopted the resolutions and recommendations and is therefore expected to ensure implementation thereof.

- The furtherance of the right to healthcare services as enshrined in the bill of rights, chapter 2, section 27 of the constitution of the Republic of South Africa, 1996.
- Recognition of the reality that the majority of South African people still use and continue to rely on ATM for their primary health care needs.

Despite this major breakthrough, very little has changed at the level of delivery and therefore a rich resource of healthcare may remain largely untapped in particular THPs.

A study by Madiba (2010:224) revealed that the Botswana health policy of 1995 forms the basis of collaboration between BHPs and THPs; however, the policy does not specify when and how often the two sides should meet. This clearly indicates that there is lack of specific guidelines on collaboration which had negatively affected the collaboration effort. This is similar to the South African situation where the legislative frameworks are neither specific, nor descriptive of what recognition of the THPs in the health system entails; except that THPs are expected to register with the Interim Traditional Health Practitioners Council. The emphasis is only on recognition of THPs but the scope, framework or Terms of Reference encompassing their recognition as part of the healthcare system is not explicit. This then creates a challenge to both the THPs and CNs not understanding what is expected of them as healthcare professionals. This statement supports Ternbani (2009:212) who observed that both THPs and Allopathic practitioners had ambivalent views regarding the impact of legalising the THPs.

In South Africa, the government, through the National Department of Health, made interventions towards the official recognition, institutionalization and empowerment of African Traditional Medicine (ATM) through the following:

- The National Drug Policy (1996) that recognises, the potential role and benefits of available remedies of ATM in the national health system and the potential role of traditional healers in the formal health care sector.

- The Directorate: The Traditional Medicine, a new directorate that was established to manage the work related to Traditional Medicine within the

Department of Health, has also been extended to the Provincial Departments of Health.

- The Traditional Health Practitioners Act, Act 22 of 2007 which was endorsed in January 2008. This Act provides for the legal recognition of traditional medicine in SA as part of the wider healthcare system.
- Draft policy on ATM for South Africa (2008:13) for the institutionalization of ATM.

Despite the major breakthrough by the government to officially recognize the THPs through legislative frameworks the following limitations and weaknesses have been identified:

- Very little has changed at the level of health care delivery between the THPs and the formal health sectors. The THPs Act, Act 22 of 2007, there are no specific regulations to the Act and the interim Traditional Health Practitioners' council is not yet grounded,
- Unequivocally delineated policies at national, provincial and local levels are necessary to guide and facilitate inter-professional collaboration as absence of these may create a sense of despondency among THPs, and
- There are no clear guidelines as to how the THPs are to be recognized as part of the healthcare system of SA. There is no indication as to how other healthcare professionals are to be engaged with the THPs in the provision of healthcare.

2.5 Barriers to Inter-professional collaboration

Figure 2.1: Barriers to inter-professional collaboration

Figure 2.1 outlines barriers to inter-professional collaboration as depicted from the literature review. Martin et al. (2010:9) and Purden (2005:228) highlighted the following barriers to IPC: Time pressure, lack of explicit descriptions and understanding of each other's roles and tasks and failure to reach consensus on roles and working relationships, poor organizational support and vertical management structures with discriminatory power structures. Different traditions and professional values, lack of confidence professionals have in the knowledge, skills and judgment of their paraprofessional colleagues. Peltzer et al. (2006:689) highlighted that low literacy among THPs and lack of modes and mechanisms of referrals needed to be improved as they were barriers to collaboration.

Healthcare professionals should be aware of barriers to collaborations and devise ways and means of dealing with these barriers to ensure that inter-professional collaboration is facilitated and sustained for better PHC service delivery.

Madiba (2010:223) concluded that lack of referral guidelines might be a barrier to inter-professional collaboration.

Findings from literature highlighted aspects that are barriers to inter-professional collaboration. These aspects provide proponents of inter-professional collaboration to ensure that strategies are developed to avoid or prevent these barriers so that collaboration can be improved. There is limitation with regard to the influence of culture as an aspect of barrier to inter-professional collaboration.

2.6 Summary of limitations and strengths of the reviewed literature

There are many concepts which were used by the researchers for Western medicines; the commonly used concepts were: Biomedical Health Practitioners, modern practitioners and Western medicines). For the purpose of this research the concept Community Nurses (CNs) was used. There is also no clear inter-professional collaboration model however there is a need for inter-professional collaboration to be initiated. Issues of respect and trust still need to be unpacked and analyzed from a practical point of view in collaboration. There is limited empirical information on positive or negative attitudes of THPs or Biomedical Health Practitioners.

It is very clear that most research findings revealed one-way referral system commonly from the THPs to CNs. Reasons for one-way referral have been highlighted, therefore strategies must be introduced to address the reasons cited, so that a two-way or cross referral system can be encouraged and advocated in case a need arises. There is also a need for setting of referral criteria and formalization by the Department of Health.

The reviewed literature highlighted the importance of improving the skills and knowledge of THPs on HIV/AIDS, STIs and TB. This is appreciated even though training is only focusing on the THPs. The move will also assist in addressing the twin epidemic of HIV/AIDS and TB even though there is no reciprocal learning especially from the CNs who are not prepared to learn from the THPs.

Despite the major breakthrough by the government to officially recognize the THPs through legislative frameworks, the following limitations and weaknesses have been identified:

- Very little has changed at the level of healthcare delivery between the THPs and the formal health sectors, and
- The THPs Act, Act 22 of 2007, there are no specific regulations and policies that guide both healthcare professionals about what the collaboration expectations are. Therefore they are currently shooting from the heap. There is a need to set guidelines that may be reviewed from time to time as need arises.

CHAPTER 3

3. Methodology

3.1 Introduction

This chapter focused on research design and methodology of the study. The researcher aimed at investigating and describing the nature and extent of inter-professional collaboration between the Traditional Health Practitioners (THPs) and Community Nurses (CNs)on inter-professional collaboration in Primary Health Care (PHC) provision. The approach of the study was quantitative.

3.2 Study design

The approach for this study was quantitative with cross sectional survey design. Survey design refers to a non-experimental research in which information is gathered through direct questioning (Polit & Beck, 2006:511). The design provides quantitative description of attitudes of a population by studying a sample of that population (Creswell, 2009:145). In this study the population was Traditional Health Practitioners (THPs) and Community Nurses (CNs).

Cross sectional designs involve the collection of data from one point in time: the phenomena understudy are captured during one period of data collection and describe the status of phenomena or relationship among phenomena at a fixed point in time (Polit & Beck, 2004:166). The survey design was chosen with the purpose of generalizing or making claims from a sample to a population so that inferences can be made about some characteristics, attitudes or behavior of the population under study (Creswell, 2009:146). The survey design has been chosen so as to cover a large sample and a rapid turnover in data collection.

3.3. Study setting

Figure 3.1: Ngaka Modiri Molema Health District

Source (Ngaka Modiri Molema Health District report: 2011)

3.3.1 Study setting for the THPs and CNs

The study was conducted within the Ngaka Modiri Molema health District in the North West Province of South Africa for both the THPs and CNs. The district has five sub-districts namely: Tswaing, Ditsobotla, Mafikeng, Ratlou and Ramotshere – Moiloa. The district has sixteen (16) Community Health Centers (CHCs), Seventy three (73) clinics, seventeen (17) mobile and two(2) health posts clinics (NMM district report, 2011). CHCs render twenty four (24) services whereas fixed and mobile clinics render an eight (8) hour service. The CNs are expected to render comprehensive health care services in these facilities whereas the THPs render their health care services at their homes.

3.4 Population and sampling

Polit and Beck (2006:506) define population as entire sets of individuals having some common characteristics.

3.4.1 Target population

3.4.1.1 Target population for THPs

The target population for this study was the THPs as described in the operational definition within NMM district in the North West Province. The population understudy met the following eligibility criteria:

- Categories of THPs as defined in THPs Act, Act 22 of 2007 that is Traditional Doctors, Diviners (*sankoma*), Traditional surgeons, Traditional Birth Attendants (TBAs) and Herbalists. The actual number of THPs was not known to the researcher.

3.4.1.2 Target population for CNs

The target population for this study included all CNs as described in the operational definition within Ngaka Modiri Molema district in the NWP. The total number was eight hundred and thirty nine (839) as reflected in table 3.1.The population understudy met the following eligibility criterion:

- Practicing community nurses: as described in the operational definition.

Table 3.1: The population for the CNs

Sub- districts	Professional Nurses (PNs)	Staff Nurses (SNs)	Auxiliary Nurses(ANs)	Total number of nurses
Ratlou	70	9	59	138
Mafikeng	132	6	88	226
Ramotshere-Moiloa	108	10	54	172
Ditsobotla	80	10	77	167
Tswaing	79	8	49	136
Subtotal	**469**	**43**	**327**	**839**

Source (NMM Sub- districts reports, 2011).

3.4.2 Sampling designs, methods and sample size for the THPs and CNs

Sample refers to a sub set of a population selected to participate in a study (Polit & Beck, 2006:509). Sampling refers to a process of selecting a portion of the population to represent the entire population (Polit & Beck, 2006:509).

3.4.2.1 Sampling design and methods

In this study, non-probability sampling design was used for both THPs and CNs. Non- Probability sampling refers to selection of sampling units from a population using non-random procedures such as convenient and purposive sampling (Polit & Beck, 2004:725).

3.4.2.2 Sampling Technique for THPs

Snowballing sampling technique was chosen for the THPs and it is a technique where early sample members are asked to identify and refer other members who meet the eligibility criteria (Polit & Beck, 2004:292). The sampling technique has been chosen by the researcher because it might have been difficult to identify other THPs, and the researcher requested referrals by the THPs to their colleagues who are not known to the researcher and the network continued until the desired sample size was obtained.

3.4.2.3 Sampling Techniques for CNs

Convenient sampling technique was chosen for CNs. Convenient sampling entails using the most conveniently available people as study participants (Polit & Beck, 2004:292). The technique was used for CNs who are readily available because the challenge is that community nurses have off-duty schedules; as a result, some nurses were off-duty or on leave.

3.4.2.4 Sample size for the THPs

Sample size for the THPs depended on the number of THPs interviewed as there was no definite database per district; however a total of two hundred and seventeen (217) THPs were interviewed.

3.4.3.5 Sample size for the CNs

The sample size selected from the total number of eight hundred and thirty nine (839)community nurses in the NMM district was approximately (264) two hundred and sixty four, calculated by using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) Accessed on 5/18/2011).

3.5 Data collection

3.5.1 Instrument and data collection for the THPs

A questionnaire was used to collect data from the THPs refer (Annexure E).This was developed in English (Annexure F) and translated to Setswana by the researcher in consultation with the retired school inspector who was a language expert. The questionnaire was divided into two sections as follows:

- Section 1 : Biographic data; *Karolo 1 : Botshelo jwa gago*
- Section 2 : Collaboration elements; *Karolo 2 : Dintlha tsa tirisano- mmogo*

Section 1: Biographic data; *Karolo 1: Botshelo jwa gago*

This section covered biographic aspects such as: gender, age, residential area, marital status, level of educational, religion, who they consult when sick, category of THP, period of training, affiliation to Traditional Healers Organization and Interim THP council, number of patients seen per month, years of experience and extent of willingness to collaborate with the CNs.

Section 2: Collaboration elements; *Karolo 2: Dintlha tsa tirisano-mmogo*

This section covered the following elements of inter-professional collaboration between the CNs and the THPs: mutual respect, mutual understanding and respect, attitudes, referral system and support. Categorical scales or dichotomous questions of Yes or No were used and any justification or elaboration was followed up with an open- ended question.

The researcher opted for a questionnaire to cater for geographically dispersed sub-districts of NMM district.

3.5.1.1 Procedure for data collection for THPs

Appointments were made in advance with the THPs through the sub- district THP coordinators. Data was collected at agreed convenient areas by the researcher. THPs who reside within nearby clinics were requested to gather at the clinics or designated areas for convenience and only a few were interviewed at their homes by the researcher. Face-to-face interviews were conducted in Setswana as the respondents were mainly Setswana speaking people. The respondents were grouped, with each THP completing his or her own questionnaire without discussing it with one another. The researcher was available to complete questionnaires for those THPs who could not write. The researcher also provided clarity where it was needed. Data was collected from two hundred and seventeen (217) THPs.

3.5.2 Instrument and data collection for CNs

A self constructed questionnaire was developed in English and was used to collect data from CNs, since all the CNs in the NMM district understood English. The questionnaire was divided into two sections which are:

- Section 1: Biographic data
- Section 2: Elements of collaboration

Section 1: Biographic data:

This section covered biographic aspects such as: gender, age, residential area, marital status, educational qualification, religion, who they consult when sick, category of THP, period of training, affiliation to traditional healers association and interim THP council, number of patients seen per month, years of experience and extent of willingness to collaborate with the CNs.

Section 2: Elements of collaboration:

This section covered the following elements of inter-professional collaboration between the CNs and the THPs: -mutual respect, mutual understanding and respect, attitudes, referral system and support. Categorical scales or dichotomous questions of Yes or No were used and any justification or elaboration was followed up with an open- ended question. The researcher opted for a questionnaire to cater for geographically dispersed areas of NMM district.

3.5.2.1 Procedure for data collection for CNs

Questionnaires were hand - delivered and distributed to various clinics and CHCs in the following sub-districts of NMM, Tswaing, Ditsobotla, Mafikeng, Ratlou and Ramotshere – Moiloa. This was to ensure sub-district representativity and for possible generalization of the results. The questionnaires were collected after three (3) days for nearby clinics and HCs that are within Mafikeng sub-district and were collected after one to two weeks in other sub-district through the assistance of local health managers. Two hundred and sixty four (264) questionnaires were distributed to CNs and a total of two hundred and two (202) were returned.

3.6 Pilot study

Pilot study refers to a small scale version or trail run done in preparation of the major study (Polit & Beck, 2004:727). A pilot study was done in the Mafikeng sub-district of NMM for both THPs and CNs. The purpose of the pilot study was to identify the feasibility of the study, to test the appropriateness and quality of questionnaires and to make appropriate corrections and modifications.

3 .6.1 Pilot study for THPs and CNs

Five (5) THPs were interviewed and it took about twenty (20) minutes for the researcher to complete a questionnaire for each THP. These THPs did not participate in the main study. Five (5) questionnaires were distributed to CNs at a

five day clinic which did not form part of the main study. Questionnaires were collected the following day.

3.6.2 Outcomes of the pilot study

The following corrections were made in a questionnaire. Yes or No was not included in one item and this was corrected in the final questionnaire. Marital status was not included for CNs and it was later included. All participants showed interest in the study as the response rate for the questionnaire was very quick from the CNs. Two CNs, that is one registered and one enrolled nurses managed to fill in the questionnaire immediately and indicated that the research topic is important to nursing care delivery.

The THPs who were interviewed were able to inform the researcher about other THPs in the vicinity. The THPs and CNs were asked about the whole interview and the questionnaire, and they indicated that the questionnaire outlined the important information on collaboration and they were grateful wanting to see real collaboration happening.

3.7 Validity and Reliability

3.7.1 Validity

Burns and Grove (2005:215) refer to validity as the extent to which findings reflect the true reflection of reality, and Polit and Beck (2006:328) define validity as the degree to which an instrument measures what it is intending to measure.

3.7.1.1 Content validity

Content validity refers to the degree to which the items in an instrument adequately represent the universe of content for the concept being measured (Polit & Beck, 2004:715).Content validity was ensured through:

- Questionnaires were developed after reviewing literature on inter-professional collaboration between the THPs and CNs. This was done to ensure content validity. Section two of the questionnaire had inter-professional collaboration elements which were formulated to respond to the research objectives. Elements such as mutual respect, mutual understanding and trust, attitudes, referral, and support were covered in section two of the questionnaire. Each main element had sub-items that seek to respond to the study objectives.

- The draft questionnaire was reviewed by a colleague and by the supervisor to assess whether all relevant elements of inter-professional collaboration were included in the questionnaire and if they were in line with the research objectives. All questions were cross-checked to ensure completeness. The questionnaire was pretested during pilot study and minor changes, adjustments and modifications were done. Almost the same questionnaire was distributed to both the THPs and CNs.

3.7.2 Reliability

Reliability refers to the degree of consistency with which an instrument measures the attribute it is designed to measure (Polit & Beck, 2006:508).

3.7.2.1 Internal Consistency

Internal Consistency refers to the degree to which the sub-parts of an instrument are all measuring the same attribute (Polit & Beck, 2004:721). Questionnaires were developed in line with the study objectives to ensure consistency. The instrument has itemized elements and sub- items which were derived from the literature. There are sub-questions under each element to solicit the relevant information on inter-professional collaboration.

3.8 Ethical consideration

The research was conducted after obtaining ethical clearance from the North West University's Committee for Research in Mafikeng campus(refer to ethics approval annexure H). Permission to undertake the study was granted by the North West Department of Health, Chief Director District Health Services, local health area managers, facility managers, Community Nurses and the Traditional Health Practitioners (refer to annexure I and J). Respondents received explanation on the topic, purpose and objectives of the study. The following moral principles were adhered to:

3.8.1 Autonomy

The rights and dignity of respondents were maintained. The respondent's rights to continue or discontinue with the study was explained and accepted without any prejudice. Respondents were given information sheet (Annexure A) about the study and there was no form of coercion. No one was forced to participate in the study.

Anonymity and confidentiality were ensured by: assuring respondents that they were not expected to write their names or any form of identification on the questionnaire. Names of respondents and their clinics would not be disclosed or displayed anywhere in the study. Data collection instruments would be kept safe for seven years and it would then be destroyed. The results of this study would be communicated to THPs and CNs through seminars and workshops, and finally respondents were assured that the information provided would not be accessible to parties other than those involved in the research and that information obtained from the study would not be used against them.

3.8.2 Justice

The respondents were given full information about the nature of the study and their right to refuse to participate. Elements of inter-professional collaboration were asked for both THPs and CNs.

3.8.3 Non –maleficence

Freedom from harm: Sensitive questions were carefully phrased to protect respondents from psychological harm; debriefing sessions would be arranged if necessary. There was no evidence of psychological harm from both the THPs and CNs therefore, it can be concluded that there was no debriefing sessions, instead, respondents acknowledged the study. Freedom from exploitation: respondents were assured that the data collected would not be used against them or their profession in anyway; however, the results will be communicated to them during seminars. The researcher ensured that there searcher or respondent relationship for the study was not exploited in anyway.

3.8.4 Beneficence

The outcome of the study will be communicated to respondents through workshops, seminars and publications. After the completion of this study, the study results may increase their knowledge about inter-professional collaboration issues. The findings may be a tool to improve the health of the communities.

3.9. Data analysis

To assist in summarizing data, appropriate tables, percentages and graphs were used. Data was analyzed descriptively using version 20 of the Statistical Package for Social Science (SPSS).The purpose was to make sense of gathered quantitative information. Data analysis for both THPs and CNs followed the same pattern as most of the questions were almost similar for biographic and elements of collaboration sections.

Descriptive statistics was used to describe data collected from THPs and CNs to reduce and summarize large amount of data to facilitate the drawing of conclusions. Graphs, frequency distributions and cross-tabulations were used to analyze data. Chi square statistics was used to analyze the associations between variables. The level of significance was set at 0.05

3.10 Summary

This chapter described the study design which was cross sectional. The study was conducted in the five sub-districts of Ngaka Modiri Molema district in the NWP. The population for the study was THPs and CNs. Sampling design was non-probability using the snowballing and purposive convenient sampling techniques.

A questionnaire was used to collect data. Pilot study was conducted to assess the feasibility of the study. Validity, reliability and ethical consideration were outline

CHAPTER 4

4. Results and discussions

4.1 Introduction

The results and findings of the study are presented in this chapter according to the study objectives to ascertain whether they addressed the objectives. Findings will cover relevant biographic data and elements of inter-professional collaboration between the THPs and CNs.

4.2 Findings

Findings are presented in frequency tables, graphs or charts and cross-tabulation. Response rate for THPs was 217 (100%) because questionnaires were collected on the same day of the interviews whereas for the CNs the response rate was 202 (77%) because the questionnaires were returned after one to two weeks in some sub-districts.

4.2.1. Biographic Data Analysis

4.2.1.1 Gender

The majority of healthcare professionals were females 326 (77,8%) whilst 93 (22,2%) were males. The gender distribution for CNs was as follows: 85, 4% of CNs were females while 14, 6% were males. THPs accounted for 70,6% of females as compared to 29,4% of males.

Discussions on gender

This study revealed that the majority of healthcare professionals were females this is more or less the same percentage for the study conducted by Madiba (2010:220).

Ndhlalambi (2009:41) found that out of eighty (80) THPs, sixty (60) were females

and twenty(20) were males. It could be associated with Florence Nightingale (*the lady with a lamp*)a woman caring for the sick during the Crimean war and that traditionally; women were caring for the sick at home. In the nursing profession the issue of gender equality in recruiting males in the caring profession needs to be realized even though nursing was predominantly perceived to be a women's profession. The other factor as cited in Wikipedia could be due to the fact that Ngaka Modiri Molema district, has 51, 8 % of females.
http://en.wikipedia.org/wiki/Ngaka_Modiri_Molema_District_Municipality. Accessed 2011/11/15.This observation is supported by the SANC nursing manpower geographical distribution.
http://www.sanc.co.za/stats/stat2011/Distribution%202011xls.htm. Accessed on 3/18/2012.

4.2.1.2 Age

The oldest THP was eighty five (85) years with more than fifty (50) years experience as a THP while the youngest THP was twenty one (21) years old. The oldest CN was seventy seven (77) years old otherwise the second oldest age was sixty two (62) years and only two CNs were within this age while the lowest age for CNs was twenty two (22) years old. The modal age for the CNs was forty (40) years while that of THPs was fifty four (54) years.

Discussions on age

The findings are similar to that of Ndhlalambi (2009:41) who found that the oldest THP was eighty eight (88) years old while the youngest was twenty five (25) years old. The oldest CN was seventy seven (77) years old; it is assumed that this CN is probably one of the retired nurses who are doing shift working sessions because the cut off age for retirement is sixty five (65) years. It is assumed that healthcare professionals at the modal age reflected for CNs and THPs have more experience in healthcare service delivery and therefore could contribute positively towards inter - professional collaboration through mutual teaching and advices. Harmful healthcare practices can be discarded by experienced healthcare professionals and the best

practices could be accommodated. This will be aligning to Leiningers' Culture Care Diversity and Culture Care Universality in that her three modes of culture care could guide care practices Leininger in (George,2002:494).

4.2.1.3 Categories of Health Care Professionals (HCPs)

4.2.1.3.1 Community Nurses (CNs)

The majority of CNs 153 (75%) were Professional Nurses, followed by 38 (18, 5%) Auxiliary Nurses and the lowest 14 (6, 8%) were Staff Nurses.

Discussions on CNs

In this study Professional Nurses accounted for majority of CNs. This is congruent with the SANC nursing manpower geographical distribution where Staff Nurses accounted to be the lowest among the nursing professionals. http://www.sanc.co.za/stats/stat2011/Distribution%202011xls.htm. Accessed on 3/18/2012.

4.2.1.3.2 Traditional Health Practitioners (THPs)

The majority of THPs121 (56, 5%) were traditional doctors, 36 (16, 5) herbalists, *sankomas 36* (16, 5), TBAs14 (16, 5%) and the lowest being traditional surgeons with 7 (3, 3%).

Discussions on THPs

In this study, traditional doctors accounted for majority of THPs. The findings are similar to what Ndhlalambi (2009:41)found that, the majority (85 %) of THPs were traditional doctors. THPs represented the highest percentage of healthcare professionals for this study. The illustration supports the statement that in South Africa, there is an estimation of 200'000 THPs as compared to 25000 conventional

medical practitioners (Elujoba et al.,2009;2).For collaboration to be successful, all healthcare professionals should be fully utilized for their diversified expertise.

4.2.1.4 Levels of education for THPs:

Table 4.1:Levels of education for THPs

Levels of education	(N)	%
No schooling	37	17.3
Below matric	164	76.6
Matric or grade 12	10	4.7
Diploma	3	1.4
Total	**214**	**100%**

Discussions on levels of education for THPs

The majority of THPs were below matric or grade 12 level. The study by Makoa (2000:119) revealed that 63, 3% of her participants were below matric. The above results accounted for the fact that the majority of THPs are not formally educated therefore any collaboration dialogues, discussions and training should accommodate those THPs who cannot read or write. Training materials should be user friendly and accommodate educational levels of all THPs. This therefore, means that role plays, posters, illustrations and scenarios should be used in the language that is commonly used. Policy documents and referral forms should be developed in such a way that they could be easily understood by THPs and are user friendly for better implementation. There is still room for THPs to improve their level of education through the Adult Basic Education programme especially those who have never attended any schooling.

4.2.1.5 Distribution of Sub-districts representation

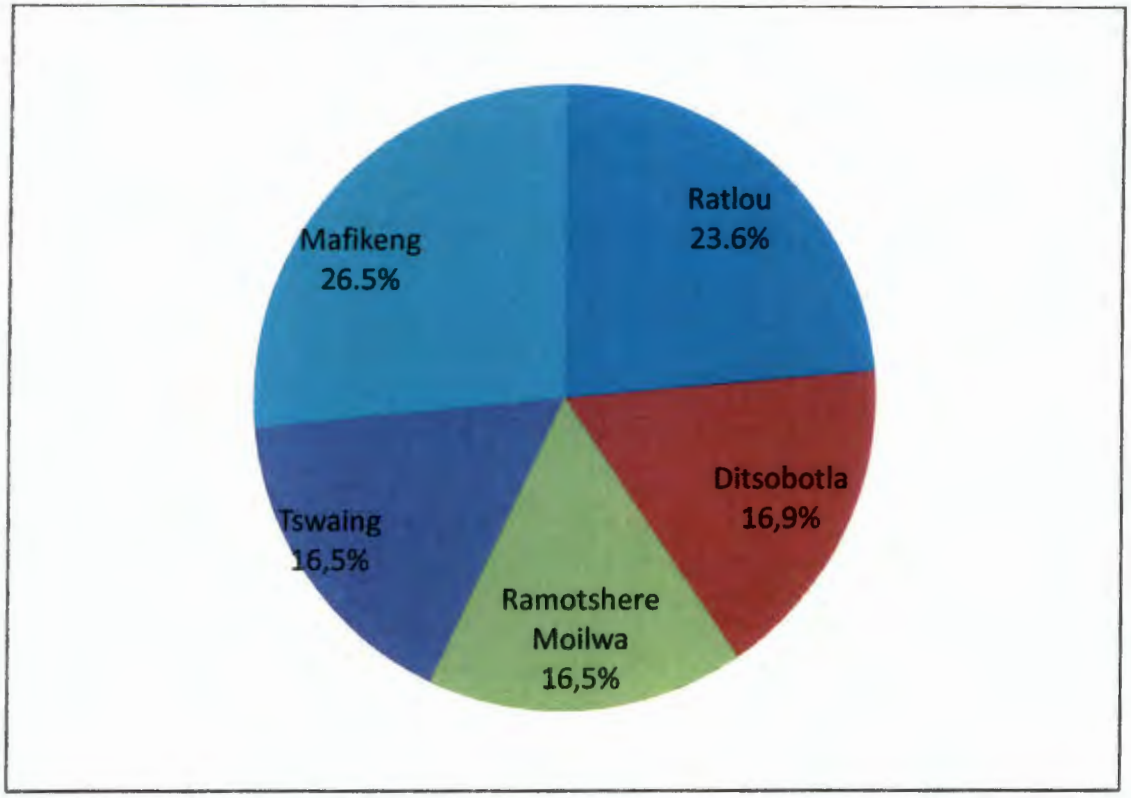

Figure 4.1 Sub-district representation of Healthcare Professionals

Figure 4.1 Illustrates that about 111(26, 5%) of Healthcare professionals were from Mafikeng sub-district,99 (23, 6%) from Ratlou, 71 (16, 9%) from Ditsobotla, 69 (16, 5%) from Tswaing and 69 (16, 5%) from Ramotshere- Moiloa, all the sub-districts were represented in this study.

Discussions on sub-districts representation

The majority of healthcare professionals were from Mafikeng sub- district. This could be attributed with the high number of two hundred and twenty six (226) CNs in Mafikeng sub-district as reflected in table 3.1. In this study, all sub-districts in the NMM district were represented for both the CNs and THPs and this will provide a valid reason to generalize the research findings in the NMM district on inter-professional collaboration between CNs and THPs in PHC.

4.2.2 Elements of inter-professional collaboration

4.2.2.1 Mutual respect, mutual understanding and trust

4.2.2.1.1 Mutual respect

4.2.2.1.1.1 Respect each other as healthcare professionals

Table 4.2: Respect THP or CNs in their own right

Categories of healthcare professionals	Do you respect THP or CNs in their own right				Total	
	Yes		No			
Community Nurse	(N)	%	(N)	%	(N)	%
	162	82.2	35	17.8	197	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	205	95.8	9	4.2	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	367	**89.3**	**44**	**10.7**	**411**	**100.00**

Table 4.2 illustrates that 162 (2,2%) of CNs indicated that they respect THPs as healthcare professionals in their own right, similarly 205 (95, 8%) of THPs indicated that they respect CNs as healthcare professionals in their own right. Conversely 35 (17, 8%) indicated that they did not respect THPs as healthcare professionals in their own right, and 9(4, 2%) of THPs indicated that they did not respect CNs as healthcare professionals in their own right. It is important and encouraging to note that majority 367 (89.3) of healthcare professionals respect each other as healthcare professionals in their own right because mutual respect is one of the key elements to a successful collaboration.

In this study 190 (88, 8%) of THPs indicated that they respect healthcare services rendered by CNs while 24 (11, 2 %) indicated that they did not respect the health care services rendered by the CNs. A total of 139 (72, 8%) of CNs indicated that they respect healthcare services rendered by THPs while 52 (27, 2 %) CNs of indicated that they did not respect the healthcare services rendered by the THPs.

Discussions on respecting each other as healthcare professionals

This study revealed that the majority of healthcare professionals both (CNs and THPs) indicated that they respect each other as healthcare professionals in their own rights and also respect the services provided by each other; however, it is only a small percentage which seemed not to respect each other. The high percentage of respect shown by the THPs and CNs provides an expectation of positive inter-professional collaboration between the two healthcare professionals. UNAIDS (2000:34) highlighted that it is important to respect THPs as professional healthcare providers. WHO (2010:13) highlighted that inter-professional collaboration requires trust, mutual respect and joint contribution to reach a common goal. Purden (2005:229) has a similar view that respect is key element to success between and among the professionals.

Wreford (2005:59); Kayombo et al. (2007:3); Vaka et al. (2009:94); Madiba (2010:222) and Dinat (2009:12) stated that one of the key elements to a successful inter-professional collaboration is building mutual respect through dialogue, engagements, consistent exchange of information and eagerness to learn from one another.

Purden (2005:224) highlighted that mutual respect should be fundamental to the delivery of culturally competent health care to all ethnic communities. Campbell-Hall et al. (2010:623) share similar view that, in order to build mutual respect, western health care should focus on a "meaning centered care approach" which is accommodating of diverse cultural explanations of illnesses. These views are in line with Leininger's theory of Culture Care Diversity and Culture Care Universality where she outlines three culture care modes.

Culture care accommodation (negotiation) mode refers to assistive, supportive, facilitative or enabling professional actions and decisions that help people of a designated culture to adapt to or negotiate with others for a beneficial or satisfying outcome with care providers. An integrated healthcare system requires flexibility in

order to accommodate the skills and varying levels of knowledge of all practitioners through mutual respect and recognition of the contributions that all role players make (van Wyk, 2005:15).

It is however, worth noting that it is only a small percentage of CNs and THPs who seemed not to respect each other and it is not so alarming because the two healthcare professionals are operating from a different medical background. Be that as it may, mutual respect remains an important element of collaboration as it forms the basis of dialogue between THPs and CNs. It is through dialogue and discussions that similarities, differences, myths and uncertainties can be identified and strategies can be employed to handle such discussion outcomes. Wreford (2005: 59) further stated that THPs are generally interested in the idea of partnership and association with the biomedical healthcare professionals; although, their enthusiasm is rarely reciprocated. This statement could however, be attributed to lack of mutual respect; because mutual respect creates an opportunity for dialogue, discussions and deliberations on issues that affect concerned parties.

4.2.2.1.1.2 HealthCare Professionals regarding themselves as superior or better than each other.

This study found that 124(64, 9%) of CNs and 152 (71%) of THPs indicated that they did not regard themselves as superior or better than each other. Conversely 67 (35, 1%) of CNs who regarded themselves as better or superior than THPs highlighted the following reasons: they were better trained, did further investigations, work under scope of practice, guidelines, protocols and acts. On the other hand 62 (29, 0%) of THPs who regarded themselves as better or superior than CNs highlighted the following reasons: CNs did not know traditional illnesses and they treated conditions that could not be treated by CNs.

Discussions on HealthCare Professionals regarding themselves as superior or better than each other.

The high percentage of CNs and THPs who did not regard themselves as superior or better than each other supports Tjale's (2004:6) suggestion that, in realizing collaboration between the Western and traditional care practices, the question should not be which healthcare system is better, but, rather how both healthcare systems should be developed to optimally save those who participate in the overall healthcare system. There is no health system without challenges.

The less percentage of CNs and THPs who did regard themselves as superior or better than each other is not an alarming percentage because van Rensburg (2009:552) and Peltzer and Mngqundaniso (2008:381) reported that many Bio-medical health practitioners are accustomed to their position of professional dominance and control and will not easily relinquish this status feeling of superiority. The statement supports what Peltzer and Mngundaniso (2008:382) and Ndhlalambi's (2009:52) finding that most of the THPs felt that they were being undermined by the nursing staff and some nurses did acknowledge that they are undermining the THPs.

This study revealed that the majority of THPs were below matric; this could be the reason why some CNs indicated that they are superior or better than the THPs. The majority of CNs were Professional Nurses who have diploma or degree in nursing; therefore it is not surprising for CNs to indicate that they are better trained than THPs, but there is a need for inter-professional collaboration between these healthcare professionals. Healthcare professionals have unique clinical experience, skills and competencies that need to be shared, maximized and centered around patient care.

4.2.2.1.2 Mutual understanding

4.2.2.1.2.1 Recognizing each other as important contributors to healthcare service delivery.

The findings in this study revealed that 116 (63, 7%) of CNs and 196 (93, 8%) of THPs recognize each other as important contributors to healthcare service delivery. Recognition of each other is important to inter-professional collaboration. A small percentage 66 (36, 3 %) of CNs and 13 (6, 2%) THPs indicated that they do not recognize each other as important contributors to healthcare service delivery.

Discussions on recognizing each other as important contributors to health care service delivery.

The majority of CNs and THPs recognize each other as important contributors to healthcare service delivery which is a positive aspect and could form a solid foundation towards inter-professional collaboration. This recognition is important to inter-professional collaboration. Tjale and de Villiers (2004:10) highlighted that multiculturalism encourages health practitioners to understand and acknowledge other cultures and traditional practices within the socio-cultural context. The implications of culture and health issues need to be recognized by health care professionals. This can be associated with Leininger's theory on Culture Care Diversity and Culture Care Universality which aims at rendering a culture congruent care to individuals by creatively combining the professional and traditional health care systems that coexist in many societies.

Troskie (1997:38); Banfield and Lackie (2007:6); Peltzer and Mngqundaniso (2008:385); Pinkoane et al. (2008:7) and Mhame et al. (2010:45)outlined inter-professional competencies such as recognizing and respecting the role, responsibilities and competence of other professions, understanding each others worlds, work and approach to patient management in relation to one's own through demonstration of respect and trust to ensure that collaborative relationships are fostered. If both healthcare professionals mutually understand each others' role in

health care provision, this may actually strengthen sound basis for recognizing each other as important contributors to health care service delivery.

Although the findings in this study revealed a positive aspect that THPs and CNs are recognizing each as important contributors to healthcare service delivery, there is a need to create a dialogue for interaction between THPs and CNs to discuss the following:

- Clarify misconceptions and myths related to each profession,
- To lay a foundation for discussion and demystify traditional healing methods,
- Create an understanding that each healthcare system has a potential contribution towards patients' wellbeing,
- That personal interests or personal agendas are secondary to the shared goals of the collaborators,
- Discuss common grounds that exist between them and any boundaries that need to be respected, and
- The responsibilities and expectations of both the THPs and CNs should be clearly spelled out.

The above stated views are shared by Vaka et al. (2009:94); Peltzer and Mngqundaniso (2008:385); Pinkoane et al. (2008:7); Purden (2005:228) and WHO (2010:29).Mutual understanding between the THPs and CNs will not appear overnight and it therefore, needs patience from both parties for it to be realized.

4.2.2.1.3 Trust

4.2.2.1.3.1 Working openly with each other, safety and security

Table 4.3: Working with each other openly

Categories of healthcare professionals	Working with each other openly				Total	
	Yes		No			
Community Nurse	(N)	%	(N)	%	(N)	%
	144	75.8	46	24.2	190	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	213	99.5	1	.5	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	357	**88.4**	**47**	**11.6**	**404**	**100.0**

In this study 144 (75, 8%) of CNs and 213 (99, 5%) of THPs indicated that they would openly work with each other in the provision of PHC whilst 46 (24, 2%) of CNs and 1 (0, 5) of THPs, indicated that they would not openly work with each other. A total of 122 (68, 9%) of CNs and 213 (99, 5%) of THPs highlighted that they would feel safe and secured to work with one another and only 55 (31,1%) of CNs and 1 (0, 5%) of THPs indicated that they would not feel safe and secured to work with each other. The CNs who indicated that they would not feel safe and secured to work with THPs cited the following reasons: they were afraid of THPs, THPs had to be registered, some THPs were using human bodies, THPs do not have clinical records, had mistrust on THPs and do not believe in them.

Discussion on openly working with each other, safety and security

The study revealed that the majority of CNs and THPs would openly work and would feel safe and secured to work with one another in the provision of PHC. Troskie (1997:39) highlighted that trust building is important and results when the two healthcare professionals feel that their identity will be secured and they will not be overwhelmed by each other. Madiba (2010:224) found that the majority of Biomedical Health Practitioners (BHPs) were in favor of collaboration with the THPs,

although they did not trust traditional medicine because they still had negative opinions of the traditional health practice that, THPs were quacks who deceive people and that the law should be used to stop traditional health practice. However, they will only collaborate for the sake of patients.

A small percentage of CNs and THPs indicated that they will not openly work or feel secured with each other. These small percentages are however not alarming because these healthcare professionals are from a different academic perspective therefore their responses are acceptable as they are facing a new paradigm in realization of inter-professional collaboration which is not an easy task to undertake as it is a process and it need a lot of patience.

Mngqundaniso and Peltzer (2008:385) and Kaboru et al. (2006:7)highlighted that the lack of trust between the THPs and CNs can hinder the progress in patient care and they further indicated that it is important that the THPs and CNs should understand each other so as to be able to trust one another. In this study the majority of healthcare professionals have an element of trust which is important to inter-professional collaboration.

4.2.1.1.3.2 Willingness of healthcare professionals to work together

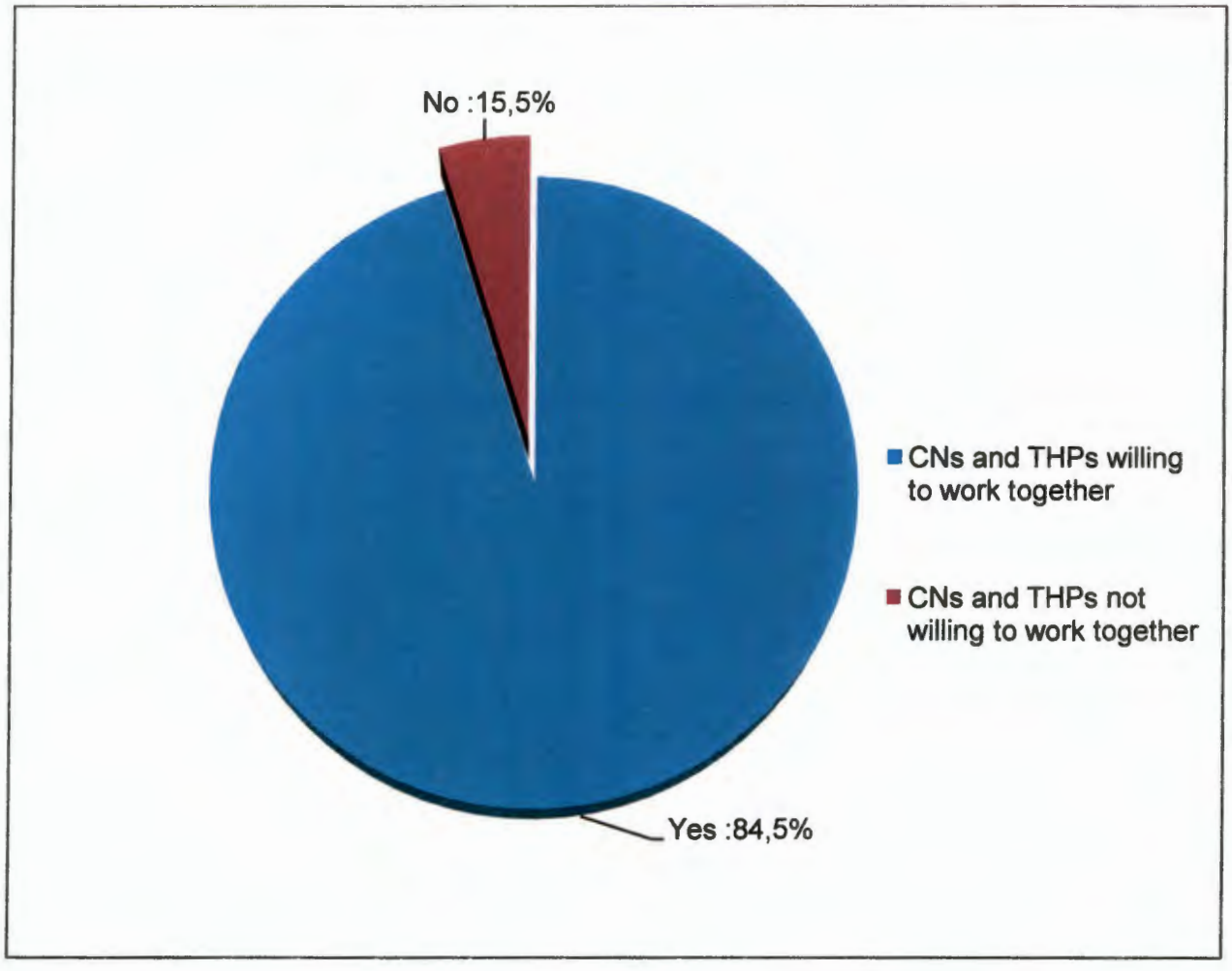

Figure 4.2: Willingness of healthcare professionals to work together

This study revealed that 344 (84, 5%) of the healthcare professionals (CNs and THPs) displayed the willingness to work together in service delivery, 69, 9% of CNs and 98, 1% of THPs were willing to work with each other. Themes identified on willingness to work together were: advices, holding meetings, referrals, respect and teamwork. A total of 63 (15, 5%) of healthcare professionals indicated that they were not willing to work with each other.

Discussions on willingness of healthcare professionals to work together

The high percentage of willingness by healthcare professionals to collaborate concurs with the findings by Troskie (1997:36) and Mototo (1999:103) that the majority of THPs were willing to collaborate with the biomedical practitioners. A less percentage of healthcare professionals indicated that they are not willing to work with each other. Kayombo et al. (2007:8) stated that initiating inter-professional collaboration between the THPs and CNs is not as easy as reflected in the literature therefore cultivating trust involves a process that may take years.

4.2.2.2 Attitudes

4.2.2.2.1 Advising patients to consult either of the healthcare professionals (CNs and THPs)

Table 4.4: The association between THPs and CNs on advising patients to Consult either of the healthcare professionals is presented on (p=0.0001).

Categories of healthcare professionals	Would you advise Patients to consult each other		Total
	Yes	No	
Community Nurses	(N) 56	(N) 128	(N) 184
Traditional Health Practitioners	(N) 207	(N) 6	(N) 213
Total	(N) 263	(N) 134	(N) 397

The association between THPs and CNs on advising patients to consult either of the healthcare professionals is presented on Table 4.6 (p=0.0001).

This study revealed that 128 CNs would not advise patients to consult the THPs whereas majority; 207 of THPs would advise patients to consult CNs. It is just a few, six (6) of THPs who indicated that they would not advise patients to consult CNs.

Discussions on advising patients to consult either of the healthcare professionals (CNs and THPs)

There was a significant association between THPs and CNs on the provision of advice to patients to consult each other. The majority of CNs would not advise patients to consult THPs whereas the majority of THPs seem to be having no problems in advising patients to consult CNs. This is contradictory to the 69, 9% of CNs who indicated the willingness to work together with the THPs in service delivery. The CNs' results therefore create a great concern for in inter-professional collaboration wherein the CNs shows a dislike of advising patients to consult THPs which is an undermining attitude.

The majority of THPs are consistent in their responses with regard to the elements of inter-professional collaboration; they display eagerness, positivity and willingness to collaborate with the CNs. It is; however, important to note that it is the prerogative of the healthcare professionals to advise the patient as to who to consult to receive healthcare service delivery and the patient has to make sound decision on the advices. It is important that in inter-professional collaboration, the healthcare professionals should make provision to advice patients appropriately and work as a team. Vaka et al. (2009:94) further emphasize that there is a need to work synergically rather than aiming at assimilation of either health care approach by the other. The goal should be geared towards the clients' wellbeing.

4.2.2.2.2 Patients consulting CNs or THPs first?

In this study 83, 3% of CNs stated that patients should consult CNs first whilst 33, 2% of THPs stated that patients should consult CNs first. A total of 15, 7% of CNs and 64, 5% of THPs indicated that patients should consult the healthcare professional they prefer first.

Discussions on patients consulting CNs or THPs first?

The majority of CNs felt that they should be consulted first; the study by Peu et al. (2001:53) had similar findings where the majority of CNs agreed that patients should visit CNs before consulting THPs. The statements support Wreford (2005:123) who concluded that biomedical practitioners clearly advocate for a clear hierarchy with the biomedical intervention having a clear priority. The responses by the majority of CNs are centered on themselves that they be consulted first. The fact that the CNs would like to be consulted first is an undermining attitude by the CNs. About 64, 5% of THPs indicated that patients should consult the healthcare professional they prefer first.

It is important that patients should be given an opportunity to choose the healthcare professional to consult first for their health problems. It is interesting to note that the majority of THPs are giving the patients a choice of consulting the healthcare professional of preference first. The patients' rights charter also provides an opportunity for patients to be referred for second opinion. Consequently patients have to make an informed sound decision about which healthcare professionals to consult first.

4.2.2.2.3 Reaction of healthcare professionals if patient consulted either first

Table 4.5: Reaction of healthcare professionals if patient consulted either first

Categories of Health Care Professionals	Your reaction if patient consulted THP or CNs first						Total	
	Anger		Neutral		Happy			
Community Nurse	(N)	%	(N)	%	(N)	%	(N)	%
	11	5.6	175	89.3	10	5.1	196	100.0
Traditional Health Practitioner	(N)	%	(N)	%	(N)	%	(N)	%
	0	.0	78	36.4	136	63.6	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	11	**2.7**	**253**	**61.7**	**146**	**35.6**	**410**	**100.0**

Table 4.5 illustrates reactions of CNs and THPs after patients have consulted either of them first. Healthcare professionals were expected to respond to the following reactions: anger, neutral or happy when the patient has consulted either CNs or

THPs first. The study revealed that 11(5, 6%) of CNs will be angry, 175(89, 3%) will be neutral while 10 (5, 1%) will be happy, conversely the THPs' reaction when patients have consulted CNs first was as follows: angry 0 (.0%),neutral 78 (36, 4%) and 136 (63, 6%) will be happy.

Discussions on reaction of healthcare professionals if patient consulted either first

The THPs' reaction of happiness when patients have consulted CNs first shows a positive attitude of the THPs. A total of 10 (5, 1 %) of CNs who indicated that they will be happy if THPs are consulted first is indicative of undermining attitudes of CNs towards THPs. The happiness reaction gap between the two healthcare providers is too wide. The high percentage of CNs' neutrality indicate that the CNs are not sure as to who should the patients consult first. It is a clear indication that THPs have no problem when patients consult CNs first as majority of them 136 (63, 6%) indicated that they would be happy if the patient has consulted CNs first. THPs are allowing patients an opportunity to consult healthcare professional of their choice.

4.2.2.2.4 Would you consult each other when sick (CNs and THPs)?

The majority 139(71, 6%) of CNs stated that they would not consult THPs when they are sick. The following themes emanated from CNs who cited that they would not consult THPs when they are sick due to; their religious beliefs, that they do not believe in traditional healers practice, they believe in scientific practice, fear of overdose, do not trust THPs' treatment or diagnosis, no infection control, no investigations that are done, no correct measurements and finally that there is also poor personal hygiene. A total of 53 (27, 3%) of CNs indicated that they would consult THPs when they are sick. Conversely 195 (91, 1%) of THPs indicated that they would consult CNs when they are sick and 19 (8, 9%) of THPs indicated that they would not consult CNs when they are sick.

Discussions on consulting each other when sick (CNs and THPs)

The majority of CNs stated that they would not consult THPs when they are sick. The latter statement could be attributed to what van Rensburg (2009:552) and Peltzer and Mngqundaniso (2008:381) reported. Their finding stated that many BHPs are still skeptical in respect of those aspects of traditional practices that have not been subjected to scientific investigation and they also view medicines used by THPs to be physiologically harmful. Conversely the majority of THPs indicated that they would consult CNs when they are sick with only a few who indicated that they would not consult CNs when they are sick. The above responses leaves much to be desired that majority of CNs have negative attitudes towards the THPs as they indicated that they do not believe in THPs practices.

4.2.2.3 Referral systems

4.2.2.3.1 Acceptance of patients referred from CNs or THPs

Table 4.6: Acceptance of patients referred from CNs or THPs

Categories of healthcare professionals	Would you accept patients referred from each other				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	195	97.5	5	2.5	200	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	208	97.2	6	2.8	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	403	**97.3**	**11**	**2.7**	**414**	**100.0**

Table 4.6 illustrates that 195 (97, 5%) of CNs agreed that they would accept patients referred to them by THPs and only 5 (2, 5%) of CNs would not accept patients referred by THPs and 208 (97, 2%) of THPs would accept patients referred to them by CNs and 6 (2, 8%) of THPs would not accept patients referred to them by CNs.

Discussions on acceptance of patients referred from CNs or THPs

The majority of healthcare professionals indicated that they would accept patients referred from one another. These results are encouraging and give hope that, the referral systems can be formally forged. There is a need for policy framework and guidelines on referral system. The relevant stakeholders should make use of this opportunity to encourage a two-way referral system. A small percentage of both CNs and THPs indicated that they would not accept patients referred by either of the healthcare professionals (CNs and THPs). These percentages are; however, not so alarming although; these healthcare professionals will be acting in contrary to the patients' right charter and the constitutional rights of freedom to healthcare services. Referral systems cannot be easily accepted by all healthcare professionals as this is a change that needs patience, thorough observations and continuous monitoring.

4.2.2.3.2 Any referral between the THPs and CNs

This study revealed that 191 (95%) of CNs have indicated that they have never referred patients to THPs, while 10 (5, 0%) of CNs indicated that they have referred patients to THPs. One hundred and forty seven 147 (84%) of CNs indicated that they would not refer patients to THPs without fear, guilt or insecurity. A total of 121 (56, 5%) of THPs have referred patients to CNs, while93 (43, 5%) accounted to have never referred patients to CNs. A total of 204 (95, 3 %) of the THPs indicated that they will refer patients to the CNs without fear, guilt or insecurity compared to 10 (4, 7%) of THPs who would not refer patients to CNs without fear, guilt or insecurity.

This study also revealed that 104 (53, 3%) of CNs have consulted patients referred to them by THPs, although 72 (66, 1%) were verbal referrals, 3 (2, 8%) were written referrals and 27 (24, 8%) were accompanied by THPs while 7 (6, 4%) of CNs could not remember how the referrals were done. On the other hand, about 69 (32, 2%) of THPs have consulted patients referred by CNs and 58 (84, 1%) of the referrals were verbal, 4 (5, 8%) written and 4 (5, 8%) were accompanied by CNs, whilst 3 (4, 3%) could not remember how the referrals were done. Most of the verbal referrals

highlighted were for the following conditions: dehydration, anemia, Tuberculosis (TB) and HIV/AIDS.

Discussions on referrals between the THPs and CNs

The majority of CNs cited that they have never referred patients to THPs. These findings indicate that majority of CNs have feelings of guilt, insecurity and fearfulness that prevent them from referring patients to the THPs. The findings of this study are similar to Makoa (2000:200) who found that 88.9 % of nurse practitioners stated that they cannot refer patients to THPs because there is no law which protects the nurse practitioner who referred to THPs. Makoa (2000:165) further found that 90% of the THPs indicated that modern practitioners are not referring patients to them for two reasons. Firstly modern practitioners do not believe in traditional practice and secondly, they do not trust them.

The majority of THPs indicated that they have referred patients to CNs; the findings are more or less similar to what Kaboru et al. (2006:6) and Ndhlalambi (2009:37) who observed that the majority of THPs reported to have referred patients to BHPs. Most of the verbal referrals highlighted by the THPs were for the following conditions: dehydration, anemia, TB and HIV/AIDS. It is encouraging to note that THPs are able to refer such challenging diseases to CNs for further management. The response is an indication that if patients' problems need a second opinion as enshrined in the patients' right charter, the healthcare professional should refer patients for second opinion.

This study revealed that a substantial percentage of the CNs are not referring to THPs, which reflects a one-way referral system. Kaboru et al. (2006:6) found that only 4% of BHPs indicated that they have referred patients to THPs. The implication of non-referral by CNs to THPs could be associated with lack of trust of services provided by THPs and this may impact on THPs who are likely to think that they are being demeaned.

The results clearly indicated that there is no formal two-way referral between the THPs and CNs. The small percentage of patients consulted by the THPs as referrals from CNs, were mostly verbal which is indicative of the fact that that referral system is mainly one- way. Peltzer and Mngundaniso (2008:385) found that the majority of THPs were willing to refer patients to the clinics while this was not true with the CNs. THPs felt that they are being undermined by CNs. CNs indicated that it is still difficult for them to refer patients to THPs as they are not officially authorized to do so.

This study revealed that majority of referrals for both THPs and CNs were verbal. The challenge is that verbal referrals could have been even self referrals, which poses a challenge of making follow up between the referring and the receiving healthcare professionals. It is however, worth noting that the results of this study accounted for one-way referral where most of the referrals between CNs and THPs will be from THPs. According to Peltzer (2009:957), the Department of Health (DoH) is currently not supporting referrals from the formal health sector to traditional health practitioners. The one-way referral could be attributed to the fact that there are no referral guidelines between the THPs and CNs, this statement is similar to what Madiba (2010:223) expressed that, lack of referral guidelines might be a barrier toward collaboration.

4.2.2.3.3 Two-way referral.

The results of this study confirmed that the two healthcare professionals are still far from implementing a two-way referral system. Pinkoane et al. (2008:7) highlighted that discussions should focus on how best a two-way referral system could be realized. Mhame et al. (2010:46) and Ndhlalambi (2009:47) evaluated a THPs project and found that there was referral of clients from the CNs to THPs for monitoring and further support. The two-way referral system is advocated for, especially where there is a need for such a referral. It is however, worth noting that CNs do not have to refer patients to THPs for the sake of two-way referral but also to provide feedback to THPs.

Mhame et al. (2010:46) concluded that any successful collaboration involves stressing complementaries of both systems by referring from one healthcare system to another. It is imperative that healthcare professionals should refer to one another when there is a need and not to refer for the sake of referring to one another but to ensure that the referral of patients to other HCPs will benefit the patient. There should be monitoring and evaluation of referral system as there is no perfect healthcare system.

4.2.2.4. Support inter-professional collaboration

4.2.2.4.1 Attending workshops together

A total of 177 (89, 4%) of CNs and 148 (69, 2%) of THPs indicated that they have never attended workshops together, while 21 (10, 6%) of CNs and 66(30, 8%) THPs highlighted that they have attended workshops between THPs and CNs. Those healthcare professionals who indicated that they attended workshops to support collaboration outlined that the following topics were discussed: HIV/AIDS, TB, pregnancy and dangers of dehydration. It is worth noting that in this study, these topics were also identified by both CNs and THPs as key topics for THPs to be trained on.

Discussions on Healthcare Professionals attending workshops together

It is with great concern that the majority of CNs and THPs in this study have never attended workshops together because it was going to create opportunities for dialogue where healthcare issues including similarities and differences could be discussed. Vaka et al. (2009:94) highlighted that it is important to create opportunities for dialogue between healthcare professionals to assist in building a basis for collaboration and understanding each others' perspectives. This might create an opportunity for supporting each other because the healthcare professionals will be having a better understanding of each others' approach to health care delivery. Figure 1.1 presents corresponding aspects of traditional and biomedical model which presents various aspects of healthcare. These various

aspects of healthcare indicate that the THPs and CNs have a common goal of providing healthcare services to the communities.

It is also through workshops that Leiningers' theory of Culture Care Diversity and Culture Care Universality could be explored with her three modes of culture care guiding the nursing care decisions and actions. Culture care preservative is whereby the CNs and THPs would discuss retention and preservation of cultural activities that have a positive impact on the wellbeing of the patients. An example of these cultural practices is putting the woolen artifacts around the child's waist, wrist or ankle to assess and monitor his or her growth and development. These best simple practices can be maintained. This will also assist in exploring ways of working synergically rather aiming at assimilating each others' approach without valid reasons.

A small percentage of CNs and THPs highlighted that they have attended workshops together. This percentage is however not satisfactory because there is a need for sharing knowledge between the CNs and THPs about healthcare issues. A small percentage of CNs who have attended workshops with the THPs; justified Madiba's finding (2010: 224) as she asserts that CNs were less willing to learn traditional medicine skills and often dominated the collaborative process.

Mhame et al. (2010:45) observed that it appears that education programs can improve the THPs general knowledge and ability to counsel clients. The latter statement is similar to the conclusion by Peu et al. (2001:53) that THPs should be fully empowered with skills of needs identification, diagnoses and management of clients particularly referral of their clients. They further indicated that better interventions need to be developed to change risk practices and encourage THPs to work with BHPs. Additionally, inter-professional projects are to share best practices, challenges and opportunities (WHO, 2010:14).

The aforementioned statement creates opportunities for culture care preservation, culture care accommodation and culture care re-patterning care as outlined by Leininger in (George,2002:560).Inter-professional education has potential outcome

of improved attitudes towards other healthcare professionals and can also improve communication among healthcare professionals (WHO, 2010:27).

Healthcare professionals who indicated that they attended workshops to support collaboration indicated that the following topics were discussed: HIV/AIDS, TB, pregnancy and dangers of dehydration. It is worth noting that in this study, these topics were also identified by both CNs and THPs as key topics for THPs to be trained on. These findings support statements by Dennil et al. (2007:184), van Rensburg (2009:553) and van Dyk (2001:9) that; in recognition of the role that THPs are playing, the DoH has initiated and developed training programmes for THPs to cover topics such as HIV and AIDS, rehydration programmes, TB, maternal and child healthcare. It is important to upgrade the skills and knowledge of THPs. The challenge is that seemingly the CNs rarely form part of the joint workshops; hence, their reluctancy towards inter-professional collaboration.

4.2.2.4.2 Information about inter-professional collaboration

This study revealed that out of 395 healthcare professionals; 207 (52.4%) indicated that they have been informed about the inter-professional collaboration between the CNs and THPs; 188 (47%) have not been informed. Nearly equal proportions of both healthcare professionals; 90 (49, 7%) of CNs and 117 (54,7%) of THPs indicated that they were informed about inter- professional collaboration between CNs and THPs while 91 (50, 3%) of CNs and 97 (45, 3%) of THPs indicated that they were not informed about inter professional collaboration between CNs and THPs.

Discussions on Information about inter-professional collaboration

The percentage of CNs and THPs who were informed and those who were not informed about inter-professional collaboration between them is worrisome because most of the healthcare professionals could have been informed by now so, as to allow them an opportunity to give it a deeper thought; it now seems like it is imposed on them especially the CNs. Vaka et al. (2009:94) highlighted that it is important to create opportunities for dialogue between healthcare professionals to

assist in building a basis for collaboration and understanding each other's perspectives .This might create an opportunity for supporting each other because healthcare professionals will be having a better understanding of each others' approach to healthcare delivery.

Both CNs and THPs expressed that they are expecting to be informed by management, clinic committees and other THPs, area managers, DoH and government. They also suggested that information should be filtered through: meetings, seminars, workshops, media, documentation, policies, nursing updates, memos and guidelines.

4.2.2.4.3 Supporting inter-professional collaboration

This study revealed that 130 (68,8%) CNs and 197(92, 1%) of THPs cited that they support the move to work together while 59 (31, 2%) of CNs and 17(7, 9%) of THPs stated that they are not supporting inter-professional collaboration. The move to support inter-professional collaboration as revealed in this study by the majority of the healthcare professionals tallies with high percentage of their willingness to collaborate with each other. Healthcare professionals who supported inter-professional collaboration cited the following aspects on their recommendations to support and make collaboration to be successful.

Table 4.7: Recommendations of THPs and CNs to support collaboration

THPs' recommendations to make collaboration successful, meaningful and lasting	CNs' recommendations to make collaboration successful, meaningful and lasting
- CNs to accept THPs' referrals and their practices, cross referrals without fear -Advise one another -Provide assistance and support from CNs and DoH -There is a need for sharing of information and ideas on health issues -Improved referral system between the two healthcare professionals - Openness and regular meetings	-Ability to manage patients -THPs to be care givers and counselors -Early and good referral system with referral letters - Attend regular meetings to discuss common Conditions -Health education through campaigns, workshops and mutual teaching -Help each other in diagnosis -Conduct meetings and education on how THPs work to improve quality of care

Table 4.7 outlines the recommendations as suggested by both the THPs and CNs to be considered to make collaboration successful, meaningful and lasting.

Discussions on supporting inter-professional collaboration

The Majority of CNs and THPs cited that they support the move to work together. The move to support inter-professional collaboration as revealed by the majority of the healthcare professionals tallies with high percentage of their willingness to collaborate with each other. Aspects that are recommended by CNs and THPs should be considered to support and make collaboration to be successful.

A small percentage of CNs and THPs stated that they are not supporting inter-professional collaboration. The percentage is; however, acknowledged by the researcher with a view that accepting change is a process; therefore inter-professional collaboration cannot be achieved overnight especially that 50, 3% of CNs and 47,6% of THPs indicated that they were not informed about the inter

professional collaboration between CNs and THPs. There is; however, a need that information sharing strategies should be reinforced.

4.2.2.4.4 Attendance of meetings that support collaboration

A total of 145 (76, 3%) of CNs and 208 (97, 2%) of THPs indicated that they would attend meetings that support inter-professional collaboration, whilst 45 (23, 7%) of CNs and 6(2, 8%) of THPs would not attend meetings which supports inter-professional collaboration.

Discussions on attendance of meetings that support collaboration

The majority of CNs and THPs indicated that they would attend meetings that support inters- professional collaboration, while a small percentage indicated that they would not attend such meetings. Healthcare professionals need to be encouraged to attend these meetings as they create opportunities for dialogue, discussions, clarification of differences and evaluation of the pros and cons of inter-professional collaboration. Makoa (2000:186) found that 70, 4% of nurse practitioners held meetings with THPs to discuss health issues. This is a positive reflection of positive attitude towards information sharing.

4.2.2.4.5 Supporting government policies, initiatives and guidelines towards Support inter- professional collaboration

In this study 154 (87%) of CNs and 208 (97, 7 %) of THPs indicated that they would support government policies, initiatives and guidelines that support inter-professional collaboration and only a small percentage of about 23 (13%) of CNs and 5 (2, 3 %) of THPs indicated that they would not support government policies, initiatives and guidelines that support inter-professional collaboration. A total of 265 (67, 6%) healthcare professionals were aware of the THPs' forum in the North West DoH and 127 (32, 4%) were not aware of the forum.

Discussions on supporting government policies, initiatives and guidelines toward inter-professional collaboration.

A substantial percentage of CNs and THPs indicated that they would support government policies, initiatives and guidelines that support inter-professional collaboration. It is encouraging to have such a substantial percentage of healthcare personnel pledging to support government initiatives. There is also a need that policies and guidelines should be user friendly and be realistic as they can be reviewed as when a need arises. There is a need to ensure that the majority of other healthcare professionals are informed of such a structure in the department.

4.2.2.4.6 Would the South African Nursing Council (SANC) allow CNs to collaborate with THPs?

This study revealed that123 (66, 1%) of CNs indicated that SANC will allow them to collaborate with THPs, while 63 (33, 9%) indicated that SANC will not allow them to collaborate with THPs. The CNs who indicated that SANC will not allow them to collaborate with THPs; highlighted the following reasons: there is no policy from SANC that indicates that nurses should collaborate with THPs and THPs are not scientifically trained.

Discussion on the (SANC) allowing CNs to collaborate with THPs?

This study revealed that the majority of CNs indicated that SANC will allow them to collaborate with THPs even though there are no policies yet, there is a need for SANC to develop guidelines for inter-professional collaboration with the THPs. The objects of the SANC are; to serve and protect the public in matters involving health services and to maintain professional conduct and practice standards for practitioners within the ambit of any applicable law (SANC, 2005:7). Furthermore; the functions of the SANC must in its decisions, take cognizance of national health policies as determined by the Minister and implement such policies in respect of nursing (SANC, 2005:7).

It is therefore, important for the SANC to express its view regarding inter-professional collaboration between the CNs and THPs; taking cognizance of the National Health Plan and the Traditional Health Practitioners Act, Act 22of 2007. A National Health Plan for South Africa (ANC, 1994:72) highlighted that all statutory bodies relevant to health will be reviewed with a perspective directed towards rationalization. Furthermore, coordination between the statutory bodies is required to ensure that they interpret and implement national health policies. The objectives shall be: to uphold the rights of patients and safeguard their interest, promote health and training standards; and regularly review the curricula of health personnel education programmes to be in line with the national guidelines (ANC, 1994:72).

4.2.2.4.7 Encouraging other CNs and THPs to support collaboration.

This study revealed that 141 (80, 6%) of CNs would encourage other CNs to support inter-professional collaboration between CNs and THPs; similarly 208 (97, 2%) of THPs would also encourage other THPs to support inter-professional collaboration. A total of 34 (19, 4%) of CNs and 6 (2, 8%) of THPs stated that they will not encourage their colleagues to support inter-professional collaboration.

Discussions on encouraging other CNs and THP to support collaboration

It is interesting and encouraging that both CNs and THPs would encourage their counterparts to support inter-professional collaboration. It is assumed that for any project to survive and to be sustained, it needs an undivided support of the people involved wherein challenges can be identified in advance and relevant interventions can be implemented.

4.2.2.4.8 Preference of CNs to collaborate with THPs

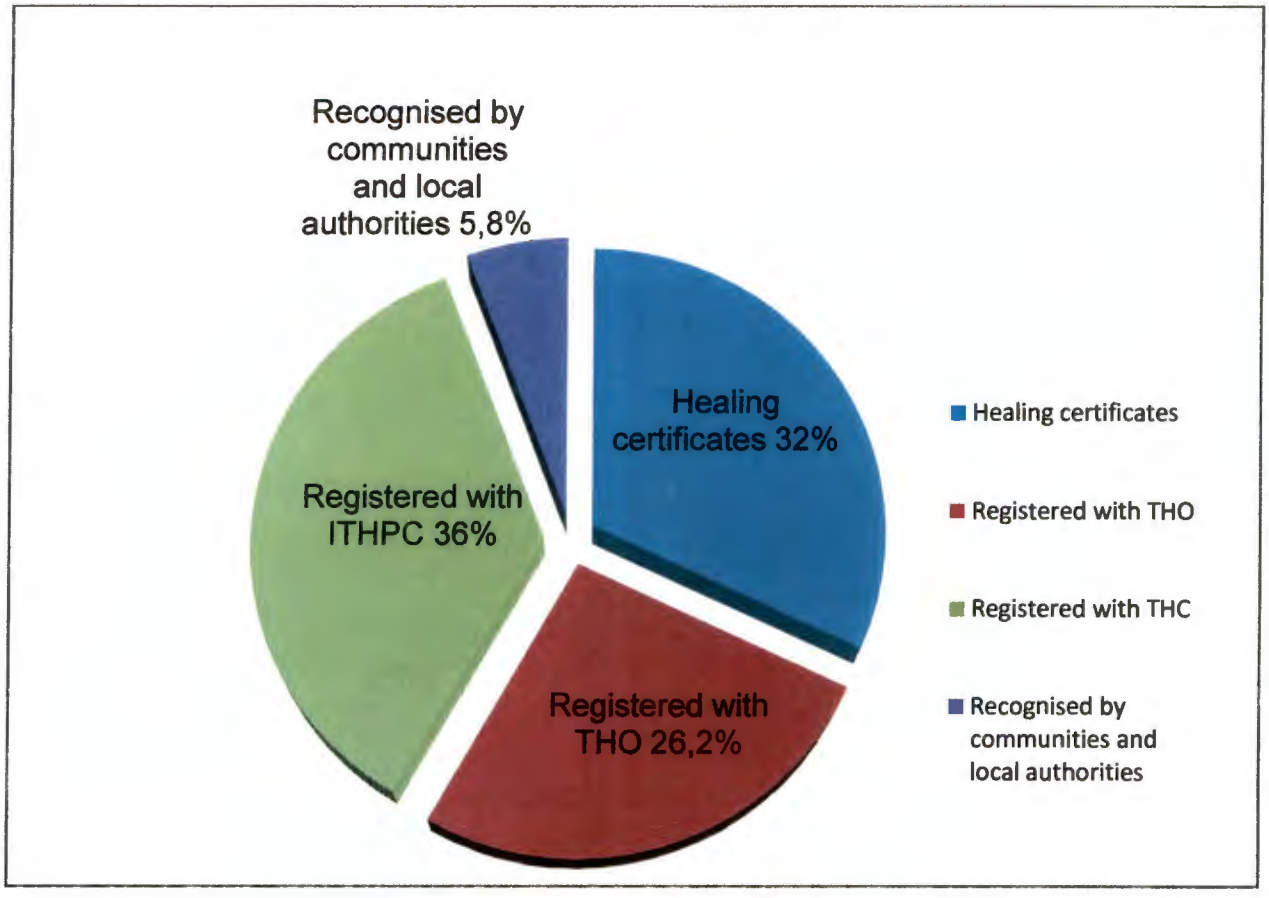

Figure 4.3: Preference of CNs to collaborate with THPs

Figure 4.3 shows that 62 (36%) of CNs preferred to collaborate with THPs who are registered with Interim Traditional Health Practitioners Council (ITHPC), 55 (32%) of CNs would prefer to collaborate with THPs who have healing certificates, 45 (26, 2%) of CNs preferred to collaborate with THPs who are registered with Traditional Healers Organization (THO) and 10 (5, 8%) of CNs would prefer to collaborate with THPs who are recognized by communities and local authorities.

Discussions on preference of CNs to collaborate with THPs

The majority of CNs indicated that they would prefer to collaborate with THPs who are registered with the ITHPC. This could ease the uncertainty of CNs and collaboration could be improved. Few CNs preferred to collaborate with the THPs; who are recognized by communities and local authorities. There is also limitation to the aspect of preferences of CNs to collaborate with THPs because the respondents (CNs) were expected to tick the appropriate column and some ticked in all the columns hence the conclusion drawn needs to be considered with some reservations.

4.2.2.4.9 Registration of THPs

This study revealed that 191 (89, 3%) of THPs highlighted that THPs should register with ITHPC or THO, while 23 (10, 7%) disagreed that THPs should register with either ITHPC or THO.THPs cited the following reasons to justify the importance for registration of THPs with ITHPC or THO: acknowledgement, proper identification, advice, protection against prejudice, joint consultation, teamwork and support.

Discussions on Registration of THPs

Majority of THPs highlighted that THPs should register with ITHPC or THO, while a few of THPs disagreed that THPs should register with either ITHPC or THO. In this study, there were no THPs who were registered with the ITHPC as required by the THPs Act, Act 22 of 2007 and the reason was that, the ITHPC was not yet functional. It is therefore imperative that processes for ensuring that ITHPC is functional be fast-tracked by the relevant authorities. The registration of THPs could also improve collaboration as majority of CNs indicated that they would prefer to collaborate with THPs who are registered with the ITHPC. It is important that THPs should register with the ITHPC or THO and to be known so that their legitimacy is not questioned. The THPs cited the following reasons to justify the importance of registration: acknowledgement, proper identification, advice, protection against prejudice, joint

consultation, teamwork and support. Registration will also assist in improving THPs' data base in the province which is currently a challenge.

4.3 Inter-professional collaboration path model

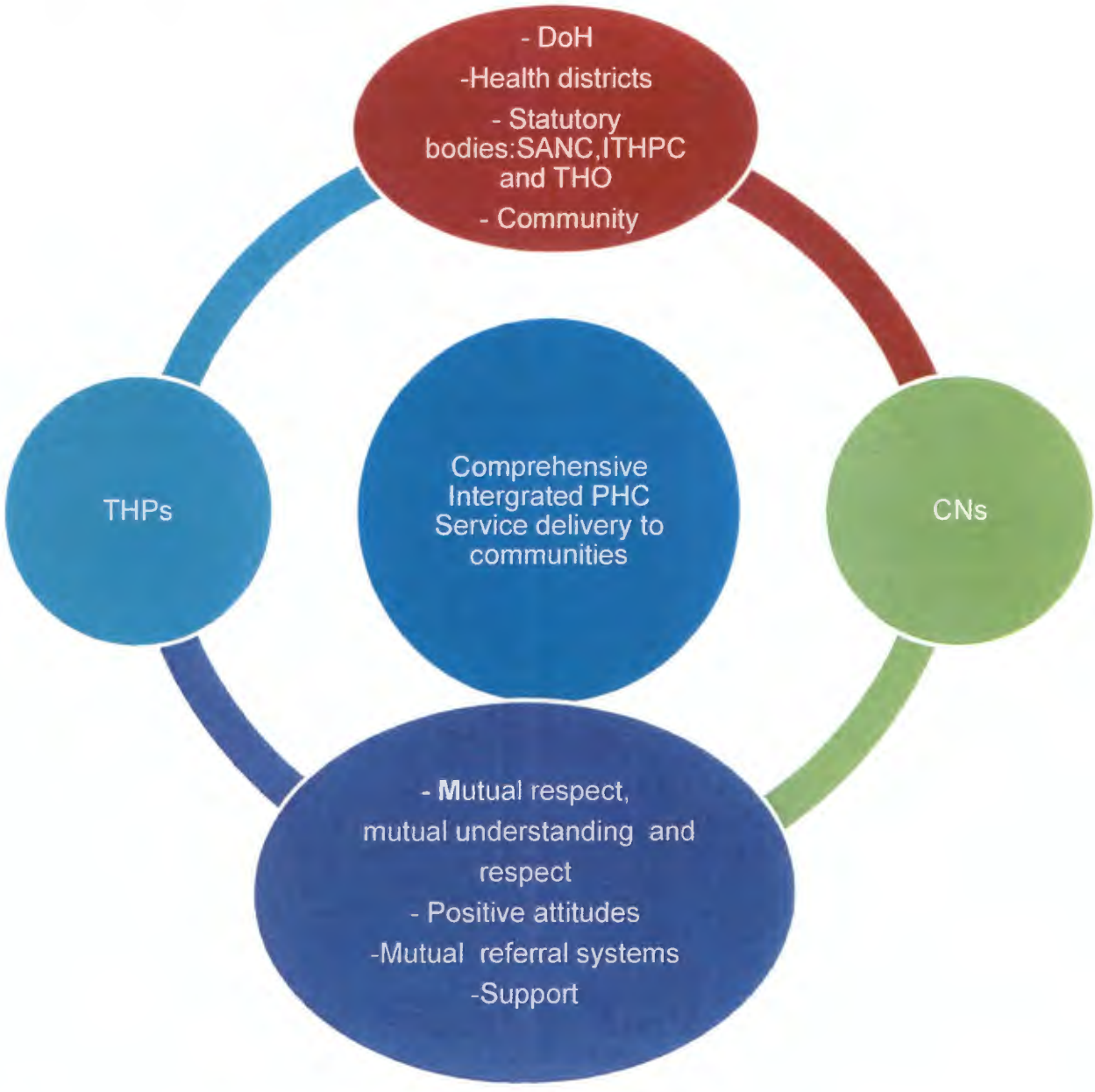

Figure 4.4: Inter-professional collaboration path model

Fig 4.4 the inter-professional collaboration path model illustrates that the elements of collaboration may lead to comprehensive integrated PHC service delivery if supported by all stakeholders. This model illustrates the central or focal area being the comprehensive integrated PHC service delivery to communities, comprehensive

services includes promotive, preventive, curative and rehabilitative services to communities. These services are provided by the THPs and CNs. These healthcare professionals should align to the elements of inter-professional collaboration such as mutual respect, trust, acknowledgement, positive attitudes, agreed upon referral systems and support should be promoted and adhered to.

If there is no mutual respect for other healthcare professionals and measures that are taken towards comprehensive integrated PHC service delivery to communities will be in vain and the DoH will not be responding to WHO's call of "integration of THPs in PHC service delivery. " There is an urgent need for relevant stakeholders to arrange meetings to create positive dialogue to clarify their positions, roles, contributions towards inter-professional collaboration in PHC delivery. There is also an urgent need for development and formulation of inter-professional collaboration guidelines by all stakeholders.

4.4 Summary

Biographic data was analyzed for both CNs and THPs including elements of inter-professional collaboration. The majority of healthcare professionals were females. Biographic characteristics of healthcare professionals in this study have no great significance towards inter-professional collaboration. Both CNs and THPs showed high percentage of mutual trust, respect and understanding towards collaboration. Majority of CNs have negative attitude as they indicated that they will not advise patients to consult THPs and would prefer patients to consult CNs first before going to the THPs.

It is clear from the results that there is one-way referral system mainly THPs referring to CNs; however, THPs were not happy with this referral system, and would like to have mutual or reciprocal referral system. It is worth noting that the majority of CNs will not refer patients to THPs for management of diseases. The majority of both professionals indicated that they support collaboration and would encourage their colleagues to support collaboration. There is; however, still a need to engage both healthcare professionals and other relevant stakeholders so as to foster inter-professional collaboration through workshops, mutual deliberations and dialogues.

CHAPTER 5

5. Recommendations, limitations and conclusions

5.1 Introduction

The purpose of the study was to investigate and describe the nature and extent of inter-professional collaboration between THPs and CNs in Primary Health care in the NMM district. This chapter therefore provides limitations, conclusion and recommendations on inter- professional collaboration between THPs and CNs as guided by study results and discussions, general discussions and interpretation of the findings.

5.2 Recommendations

5.2.1 Significance for nursing practice

Nursing fraternity: all managers and nursing practitioners should be involved from the grass root level on issues of cultural values and their impact on nursing care.
Nursing fraternity need to be reminded of the nurses' pledge, especially with regard to issues of their religious beliefs which seem to be a negating factor towards inter-professional collaboration. The patients' right charter also afford the patients an opportunity to be referred for second opinion, if the patient's condition is not improving while on medical treatment ; and he or she opts to be referred to the THPs; his or her rights should be respected. Leiningers' theory of Culture Care Diversity and Culture Care Universality could be applied to nursing practice as healthcare professionals (CNs and THPs)are caring for cultural beings with diversity and universal cultural values and beliefs. It is also important to recognize the three modes of culture care; to provide culture congruent care.

5.2.2 Nursing Education

Nursing Education Institutions (NEIs) should incorporate trans-cultural nursing in their curricula so that nursing students are orientated on trans-cultural nursing at the NEIs to avoid cultural shock in the clinical practice. Troskie (1997:41) also recommended that the inclusion of anthropology in the nursing curriculum would make students aware of cultural differences and similarities; this can be associated with Leiningers' theory of Culture Care Diversity and Culture Care Universality.van Wyk (2009:31) indicated that it is important and valuable that all students in healthcare science must learn more about traditional health practice to prepare them to render culturally congruent and safe care.

Van Wyk (2009:58)highlighted that, Departments of Nursing Science are already providing training to *sankomas.* She expressed her view in her acknowledgements, that lecturers in the health sciences face the challenge to train their students in an understanding of traditional healing of which their patients are increasingly making use of. She also complimented the staff members of the Department of Nursing at University of Pretoria, on being so open –minded and innovative that, they instituted a module in integrative healthcare in the undergraduate programme in Nursing Science.

5.2.3 Research

Findings in the study revealed that the nature and extent of inter-professional collaboration is extremely superficial. The majority of THPs and CNs showed mutual respect and understanding toward each other; however, there is still a need for further research on clinical practice regarding inter-professional collaboration between healthcare professionals. There is also a need to research into other stakeholders' views in relation to inter- professional collaboration in PHC. Framework and guidelines on inter-professional collaboration should be developed by all stakeholders and be piloted in one or two sub-districts of Ngaka Modiri Molema district.

5.2.4 Stakeholders' involvement

National Department of Health (NDoH) will have to fast-track the establishment of Interim Traditional Health Practitioners Council (ITHPC) as majority of CNs indicated that they would prefer to collaborate with THPs who are registered with the ITHPC. The North West DoH sub-directorate on special programmes will have to create an interface and foster negotiations between THPs and CNs and should not only focus on THPs.

To involve stakeholders such as: the SANC, CNs, ITHPC, THPs, Nursing Education Institutions, community representatives, clients and DoH to:

- Develop inter-professional collaborative framework ,
- Develop policy guidelines to establish a well grounded inter-professional collaboration and
- Develop monitoring and evaluation strategies and teams once the framework and policy guidelines are developed.

It is therefore important for SANC to express its view and guidance regarding inter-professional collaboration between the CNs and THPs. One of the functions of the SANC is that; it must in all its decisions, take cognizance of national health policies as determined by the Minister and to implement such policies in respect of nursing.

The level of education of THPs has to be considered when developing such guidelines as this study revealed that majority (76,6%) of THPs are below matric therefore; simple and user friendly guidelines must be developed. THPs are to be encouraged to undergo Adult Basic Education Training (ABET) especially those who never attended school; this will assist if the written referral is needed and any formal training is required or workshops. There is also a need that guidelines and Standard Operating Procedures on inter-professional collaboration should be developed about the nature; that is what collaboration should entail, how should the nature of collaboration belike and to what extent should it be operationalized between the THPs and the CNs in PHC. The SOPs and guidelines will be reviewed as when a need arise to meet healthcare service demands.

5.3 Limitations of the study

5.3.1 Limitation related to the sample size

The sample size for the CNs was two hundred and sixty four (264) as calculated by using the Raosoft sample calculator from the eight hundred and thirty nine Community Nurses. Only two hundred and two (202) CNs responded. This could be attributed to the vastness of the sub-districts, distance and reluctance of CNs to fill in the questionnaires. There was limited data base and profile of the THPs especially at the provincial and sub-district office. This made it difficult to have an estimated sample size for THPs and the researcher had to depend on snowballing sampling technique for the THPs.

5.3.2 Limitations related to data collection (instrument)

Some open-ended questions were not completed by some CNs and this made it difficult to get relevant information and explanations to areas where justification was required. The questionnaire did no capture the element of attitude in depth this was due to the fact that reviewed literature did not highlight clear explanation on attitudes. There is still a need to explore this concept. There is also limitation to the aspect of preferences of CNs to collaborate with THPs because the respondents (CNs) were expected to tick the appropriate column and some ticked in all the columns hence the conclusion drawn needs to be considered with some reservations. There were some delays in returning of questionnaires by some CNs probably due to geographically dispersed clinical areas.

5.4 Conclusion

This study revealed that the nature and extent of inter-professional collaboration between the THPs and CNs at PHC in Ngaka Modiri Molema is extremely superficial, it is not pragmatic, and therefore, it is not realized. These results of the study revealed that the there was no significant association on inter-professional collaboration between the THPs and CNs at PHC in Ngaka Modiri Molema. There is

however, a wish for the THPs and CNs to collaborate even though, this it is not yet off the ground; because there are no guidelines to guide the THPs and CNs regarding the nature that is, the what and how should collaboration be forged. There is lack of clear policy guidelines and standard operating procedures for inter-professional collaboration between THPs and CNs.

Both THPs and CNs support collaboration as illustrated by the positive response of both to the elements of inter-professional collaboration. It should however, be noted that reluctance by healthcare professionals to recognize many changes taking place in health industry and health spectrum around the globe and within the country, will negatively impact on inter-professional collaboration in providing PHC service. Until healthcare professionals agree on what inter-professional collaboration entails at all levels of health care, true inter-professional collaboration will not be observed and the benefits it offers will not be reaped.

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ANNEXURE A: INFORMATION SHEET

THE PURPOSE OF THE STUDY

The researcher embarked on the study to investigate the nature and extent of inter-professional collaboration between the Traditional Health Practitioners (THPs) and the Community Nurses (CNs) in providing Primary Health Care in the Ngaka Modiri Molema (NMM) district of the North West Province. The district has urban, peri-urban and rural context with varying access and provision of Primary Health Care (PHC) services by various service providers like THPs and CNs. Communities therefore utilize these services either singly or concurrently. The researcher therefore seeks to investigate the nature and extent of inter-professional collaboration between the two service providers. To investigate and describe the nature and extent of such inter-professional collaboration and develop recommendations based on the outcome of the study.

Procedure: The study participants (CNs) will be requested to fill in the provided questionnaires at the clinics and to ensure that all sections are filled in, as incomplete data may pose challenges during data analysis and interpretation. For the(THPs) the researcher will collect data herself by filling in the provided questionnaires. Participants will be required to fill in a consent form after reading and understanding this information leaflet. The researcher will ensure that all ethical principles are adhered that is: confidentiality, anonymity, informed consent, the dignity and privacy of the participants will be respected and protected. Their right to withdraw from the study and that no coercive measures or force to participate will be implemented

Right to withdraw: Your participation in this study is voluntary. If at any time you do not want to fill in the questionnaire or do not want to respond to any question, you may skip it. You have the right to withdraw from the study at any time.

ANNEXURE B: CONSENT FORMFOR COMMUNITY NURSES

I.....confirm that I am participating willingly in this study. The purpose, procedure, risks, benefits of the research study have been explained to me. I am aware that the results of the study including my personal details will be anonymously processed to research reports. I have had time to ask questions and have no objection to participate in the study. I understand that should I wish to discontinue with the study, my withdrawal will not affect my interaction with the researcher in any way.

Participant's signature.....Date.....

KETAPELE B: LOKWALO TETLA LA MOALAFI WA SETSO LA GO TSAYA KAROLO

Nna..... Ke tlhomamisa gore ke tsaya karolo mo patlisisong e ka bonna. Ke tlhaloseditswe ka maikaelelo, ditselana, go amega go go sa jeseng diwelang dikgatampi (dirisiki) maungo a patlisiso e. Ke lemositswe gore dipholo tsa patlisiso e , di tla phatlhaladiwa mo direpotong ntle le go tlhagelela ga diteng tsa maina a me. Ke nnile le tshono ya go botsa dipotso, ka jalo ga ke kgatlhanong le go tsaya karolo mo patlisisong e. Ke tlhaloganya gore fa ke sa batle go tswelela pele gonna karolo ya patlisiso e, nka i kgogela morago, mme se, ga se kitla se ama kgolagano ya me le mmatlisisi ka gope fela.

_____

aeno ya motsaa- karolo. / Kgatiso ya monwana o motona wa moja.

ha: _____

ANNEXURE C: PERMISSION TO CONDUCT RESEARCH

15.06.2012

TO: MR K RABANYE
POLICY AND PLANNING
DEPARTMENT OF HEALTH
NORTH WEST PROVINCE

SUBJECT: PERMISSION TO COLLECT DATA FOR A RESEARCH PROJECT

Sir
I am a Masters student at the North West University (Mafikeng campus) and currently employed by the Department of Health, training Primary Health Care (PHC) Nurses for the Ngaka Modiri Molema (NMM) district.

The research title is: "Investigation of inter-professional collaboration between the Traditional Health Practitioners (THPs) and the Community Nurses (CNs) in Primary Health Care (PHC) provision in the NMM district of the North West Province (NWP)".

The purpose of the study is to investigate and describe the nature of inter-professional collaboration between the THPs and the CNs in the PHC delivery in the NWP.

The specific objectives of the study are to investigate:

1. The specific elements of collaboration such as mutual respect, mutual understanding and trust in inter-professional collaboration between the THPs and CNs,
2. The attitude of both THPs and the CNs in collaboration,
3. To describe the referral systems between the THPs and the CNs and
4. To identify factors that support inter-professional collaboration between the THPs and the CNs in PHC.

A quantitative approach for data collection will be used as follows:
A self constructed interview schedule shall be used to collect data from the THPs through face to face interviews. The questionnaire shall be developed in English and translated to Setswana for the THPs. English questionnaire will be used to collect data from CNs at their respective clinics.

I intend to conduct the research project in the five (5) sub-districts of the NMM district I therefore request permission, to conduct the above-mentioned research project. I undertake to strictly adhere to the ethical principles of nursing research i.e. autonomy, justice, non- maleficence and beneficence.

Enclosed find the following:

- Approval letter from relevant committees at North West University (Mafikeng Campus).
- A copy of a proposal.

My supervisors are: -Professor Ushotanefe Useh : 018 – 389 2531
-Dr Eva Manyedi : 018 - 3892111

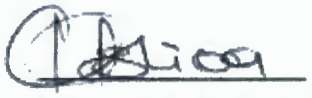
My contact details are herewith attached for further clarity:

0823554036 / 018 - 3841123

E –mail address is Mamotale@nwpg.gov.za .

Thank you in advance

Regards



Mamotale Gladys Montshioa
Masters degree student

ANNEXURE D: QUESTIONNAIRE FOR THE COMMUNITY NURSES

Introduction

The questionnaire is aiming at investigating the nature of inter-professional collaboration between the Traditional Health Practitioners (THPs) and Community Nurses (CNs) in Primary Health Care (PHC). You are kindly requested to answer each question and reflect the true and genuine response. Thank you in advance for your cooperation.

SECTION: 1

1. Biographic data

1.1. Your gender

Male		Female	

1.2 What is your age in complete years _____

1.3 Which one of the following best describes your qualification

Professional nurse	Staff Nurse	Auxiliary Nurse

1.4 How many years have you been practising as a Community Nurse_____

1.5 Which of the following best describes the area where you currently live?

Rural	Urban	Peri-urban

1.6 What is your marital status:

Married	Never married	widowed	divorcee

1.7 What is your religious affiliation _____

SECTION: 2

2. **Collaboration elements**

2.1. Mutual respect, mutual understanding and trust

2.1.1. Do you respect healthcare services provided to patients by the THPs?
Yes or No

2.1.2. Do you respect THPs as healthcare practitioners in their own right? Yes or No

2.1.3. Do you regard yourself as superior or better than the THPs? Yes or No

2.1.4. If yes explain:

_____

_____

_____

2.1.5. Do you recognize THPs as important contributors to healthcare service?
delivery? Yes or No

2.1.6. Would you openly work with the THPs? Yes or No

2.1.7. If no, state the reasons.

_____

_____

_____

2.1.8. Would you openly share your healthcare knowledge with the THPs? Yes or No

2.1.9. Would you feel safe and secured when working with THPs? Yes or No

2.1.10. If no, state reasons.

_____

_____

_____

2.1.11. Are you willing to work with THPs in the healthcare provision providing healthcare? Yes or No

2.1.12. If yes, how would you prefer to work with THPs?

_____

_____

_____

2.1.13. Do you have any THP serving in your clinic forum (clinic committee)? Yes or No

2.1.14. Have you ever attended a meeting between the THPs and CNs? Yes or No

2.2. Attitudes

2.2.1. Would you advice patients to go to the THPs for treatment? Yes or No

2.2.2. Should patients consult (see) CNs first or THPs first? Tick the appropriate block.

CNs first	
THP first	
Anyone they prefer first	

2.2.3. How would you react if you find that the patient has consulted a THP before coming to the clinic? Tick the appropriate block.

Angry	
Neutral	
Happy	

2.2.4. Would you consult the THP when you are sick? Yes or No

2.2.5. If no, state the reasons.

_____

_____

_____

2.3. Referral systems

2.3.1. Would you accept patients referred to you by THPs? Yes or No

2.3.2. Have you ever referred a patient from the clinic to the THP? Yes or No

2.3.3. If yes, state the health problem/condition that you have referred the patient for?

_____

_____

2.3.4. Have you ever consulted a patient referred to the clinic by the THPs? Yes or No

2.3.5. If yes, what was the form of referral? Tick the appropriate block.

Verbal referral	
Written referral	
Accompanied / brought by the THPs	
Cannot remember	

2.3.6. Would you refer patients to THPs without fear, guilt or insecurity? Yes or No

2.3.7. How often do you see patients that were seen by the THPs? Tick the appropriate block.

Often(regularly / many times)	
Seldom	
Never	

2.3.8. Are you afraid to refer patients to traditional healers? Yes or No

2.3.9. If yes, who are you afraid of?

_____

_____

2.3.10. Would you provide feedback to the THPs after consulting the patient? Yes or No

2.4.Support to collaboration

2.4.1. Have you ever attended a workshop or seminar with the THPs? Yes or No

2.4.2. If yes, explain what was discussed.

_____

_____

_____

2.4.3. Were you informed about inter-professional collaboration between the THPs and Community nurses? Yes or No

2.4.4. If no, who did you expect to inform you?_____

2.4.5. Do you support the move to work together with THPs? Yes or No

2.4.6. If yes, what kind of support do you recommend? State below.

_____

_____

_____

2.4.7. Would you attend meetings that support collaboration between CNs and THPs? Yes or No

2.4.8. Would you support government policies, initiatives and guidelines which support collaboration? Yes or No

2.4.9. Would South African Nursing Council (SANC) allow you to work with the THPs? Yes or No

2.4.10. If no, state your reasons.

_____

_____

_____

2.4.11. Would you encourage other CNs to support collaboration? Yes or No

2.4.12. Would you prefer to collaborate with traditional healers that have the following? Tick the appropriate column

Healing certificates	
Registered with Traditional Healers Organization	
Registered with the Interim Traditional Healers Council	
Recognized by the communities and local authorities	

2.4.13. What role do you prefer the THPs to play in collaborating with CNs in patient care? Tick the appropriate block.

Counsellor role	
DOTS supporter	
Healer role	
No role to play	

2.4.14. Have you ever heard about the Traditional Health Practitioners Act, Act 22 of 2007? Yes or No

2.4.15. Do you have the Traditional Health Practitioners Act, Act 22 of 2007 in your clinic? Yes or No

2.4.16. List at least five (5) topics that you wish THPs could be trained on?

_____

_____

_____

2.4.17. Are you aware that there is a sub-directorate at the provincial Department of Health, that deals with traditional healers' forum in the North West Province? Yes or No

2.4.18. Would you visit the THPs practice site (surgery / home) to familiarize yourself with their health practices? Yes or No

ANNEXURE E: ***KETAPELE E: LENANEO POTSOLOTSO LA BAALAFI BA SETSO***

Matseno

Maikaelelo magolo a patlisiso e, ke go leba sentle, go batlisisa mo go tseneletseng le go tlhalosa ka botlalo tirisano-mmogo mogare ga badiri ba baalafi ba setso le baoki ba dikliniki mo go neelaneng ka kalafi ya boitekanelo jwa pholoselegae. Ka moo he o kopiwa go araba potso enngwe le enngwe le go araba ka boikanyego le boammaruri. Mmatlisisike ena yo o tla kwalang dikarabomme ga a kitla a tlhagisa leina la gago. Ke lebogela tirisano ya gago kwa pele.

KAROLO YA NTLHA: 1

1.Botshelo jwa gago

1.1. Bong jwa gago?

Monna		Mosadi	

1.2. Dingwaga tsa gago tsa kgolo dikae? _____

1.3. O dula mo kgaolong efe ya tse di latelang ga jaana?

Motse-selegae	Toropo	Gaufi le toropo

1.4. Kemo ya gago ya nyalo?

Nyetse / Nyetswe	Ga ke nyala / Nyalwa	Swetswe	Tlhadilwe

1.5. O feletse mo mophatong ofe wa thuto?

Ga ke a tsena sekolo	
Mophato o o ko tlase ga materiki	
Materiki	
Dipoloma kgotsa setlankana sa thuto (setefikeiti)	

1.6. O tsena kereke efeng?

1.7. Fa o lwala o alafiwa ke ofe mo go ba ba latelang? (Tshwaya tse di maleba)

Moalafi mongwe wa setso ntle le wena	
Ke a ikalafa	
Kliniki	
Ngaka ya sekgoa	

1.8. Ke dingwaga tse kae o le moalafi wa setso? _____

1.9. O leloko la mokgatlho ofe wa baalafi ba setso, sekai: Traditional Healers Organization? _____

1.10. A o leloko la khansele ya nakwana ya bosetshaba e ntsha ya baalafi ba setso? Ee kgotsa Nyaa

1.11. O ngaka efe ya setso?

Ngaka ya ditaola	
Ngaka ya bogwera (rupisa)	
Sankoma	
Mmelegisi wa setso (Mmayabotsetsi)	
Ngaka e tšhotšha	

1.12. O alafa balwetsi ba ba kae ka kgwedi? _____

1.13. O tseile dingwaga tse kae o ikatisa go nna moalafi wa setso? _____

1.14. O eletsa go le go kae gore o ka dirisana – mmogo le baoki ba kliniki go neela balwetsi thuso ya kalafi?

Ga ke eletse le eseng	Eseng mo go kae - kae	Mo selekanyong se se fa godingwana	Ke eletsa mo tonna thata

KAROLO YA BOBEDI: 2

2. Dintlha tsa tirisano-mmogo

2.1. Tlotlano, go amogelana le tshepano

2.1.1. A o tlotla kalafi ya baoki ba kliniki eo ba e neelang balwetsi? Ee kgotsa Nyaa

2.1.2. A o tlotla baoki ba kliniki jaaka baalafi ba pholo ba ba ikemetseng?
Ee kgotsa Nyaa

2.1.3. A o ipona o alafa botoka go feta baoki ba kliniki? Ee kgotsa Nyaa

2.1.4. Fa o re Ee , tlhalosa:

_____

_____

_____

2.1.5. A o lemoga fa baoki ba kliniki ba dira karolo e e botlhokwa mo go neelaneng ka pholo? Ee kgotsa Nyaa

2.1.6. A o ka dira mmogo le baoki ba kliniki o sa iphitlhe? Ee kgotsa Nyaa

2.1.7. Fa o re nyaa: Tlhalosa mabaka.

_____

_____

_____

2.1.8. A o ka sedimosetsa baoki ba kliniki ka kitso ya gago ya kalafi ya setso o phuthulogile? Ee kgotsa Nyaa

2.1.9. A o ka ikutlwa o sireletsegile le go babalesega fa o dira mmogo le baoki ba Kliniki? EekgotsaNyaa

2.1.10. Fa o re nyaa: Tlhalosa .

_____

_____

_____

2.1.11. A o rata go dirisana le baoki ba kliniki mo go neelaneng ka pholo?

Ee kgotsa Nyaa

2.1.12. Fa o re Ee, tlhalosa gore o eletsa tirisano-mmogo enne e e ntseng jang?

_____

_____

_____

2.1.13. A o tsaya karolo mo diforamong kgotsa dikomiti tsa kliniki? Ee kgotsa Nyaa

2.1.14. A o kile wa tsena pitso/ kopano magareng ga baoki ba kliniki le baalafi ba setso?

Ee kgotsa Nyaa

2.2. Maikutlo le kgopolo

2.2.1. A o ka gakolola le go rotloetsa balwetsi go ya bona kalafi ko baoking ba kliniki?

Ee kgotsa Nyaa

2.2.2. A balwetsi ba tshwanetse go kopa thuso mo wenapele fa ba lwala kgotsa mo baoking ba kliniki pele? Tshwaya mo go maleba.

Baoki ba kliniki pele	
Baalafi ba setso pele	
Mongwe le mongwe o ba ratang go mmona pele	

2.2.3. O ka ikutlwa jang fa o lemoga gore molwetsi yo o mo alafang o simolotse ko baoking ba kliniki pele a tla mo go wena?

Nka tenega	
Siama fela	
Ke a itumela	

2.2.4. A o ka kopa kalafi ko baoking ba kliniki fa o lwala? Ee kgotsa Nyaa

2.2.5. Fa o re nyaa : tlhagisa mabaka a gago

_____

_____

_____

2.3. Go romela go kopa thuso fa o sa kgone go alafa

2.3.1. A o ka amogela balwetsi ba ba rometsweng ke baokiko go wena, go kopa thuso ya kalafi? Ee kgotsa Nyaa

2.3.2 .A o kile wa romela molwetsi yo o moalafang ko kliniking o sa kgone go moalafa? Ee kgotsa Nyaa

2.3.3. Fa o re Ee, tlhalosa: Mathata a pholo a o neng o sa kgone go a alafa?

_____

_____

_____

2.3.4. A o kile wa alafa balwetsi ba ba rometswengko go wena ke baoki ba kliniki? Ee kgotsa Nyaa

2.3.5. Fa o re Ee, ba ba rometse ka mokgwa ofe wa tse di latelang: Tshwaya se se maleba.

Ka molomo fela	
Ka lokwalo	
O ne a isitse molwestsi ka sebele	
Ga ke gopole	

2.3.6. A o kgona go romela balwetsi ko baoking ba kliniki ntle le go tshaba, go ipelaela kgotsa go ikobonya? Ee kgotsa Nyaa

2.3.7. O bona / alafa balwetsi ba ba reng ba tswa ko baoking ba kliniki go le go kana kang? Tshwaya se se maleba

Gantsi	
Sewelo	
Ga nke ke ba bona / ba alafa	

2.3.8. A o tshaba go romela balwetsi ko baoking ba Kliniki? Ee kgotsa Nyaa

2.3.9. Fa o re Ee, tlhalosa: O tshaba mang?

_____

_____

2.3.10. A o ka bolelela mooki gore bothata jwa molwetsi o a mo rometseng ko wena e ne e le eng? Ee kgotsa Nyaa

2.4. Tshegetsano le kemano nokeng ya tirisano –mmogo

2.4.1. A o kile wa tsenela dithuto tsa tshedimosetso ya pholo le na le baoki ba kliniki

Ee kgotsa Nyaa

2.4.2. Fa o re Ee, tlhagisa dintlha tse goneng go buiwa ka tsone

_____

_____

_____

2.4.3. A o kile wa sedimosediwa ka tirisano-mmogo magareng ga baoki ba kliniki le baalafi ba setso? Ee kgotsa Nyaa

2.4.4. Fa o re Nyaa, o solofetse gore o sedimosediwe ke mang le gone ka mokgwa ofe?

_____

_____

2.4.5. A o emanokeng kgato ya tirisano-mmogo gareng gago le baoki bakliniki?

Ee kgotsa Nyaa

2.4.6. Fa o re Ee, o tlhagisa gore kemonokeng e nne jang? Tlhalosa

_____

_____

2.4.7. A o ka tsenela kopano ya go emana nokeng ka maemo a pholo gareng ga baalafi ba setso le baoki ba kliniki? Ee kgotsa Nyaa

2.4.8. A o ka ema nokeng maiteko le melawana ya puso go tiisa tirisano-mmogo gareng ga lona le baoki ba kliniki? Ee kgotsa Nyaa

2.4.9. A o ka rotloetsa baalafi ba bangwe ba setso ka tirisano-mmogo gareng bona le baoki ba kliniki? Ee kgotsa Nyaa

2.4.10. A o itse sengwe ka molao o mosha wa baalafi ba setso, Molao22 wa2007?
Ee kgotsa Nyaa

2.4.11. A o itse gore gona le lekala la puso le le dirang ka foramo ya baalafi ba setso mo lefapheng la pholo la porofense ya Bokone Bophirima?
Ee kgotsa Nyaa

2.4.12.A o bona go le botlhokwa gore baalafi ba setso ba ikwadise mo ditheong tse di latelang: Mokgatlho wa baalafi ba setso kgotsa khansele ya nakwana ya baalafi ba setso? Ee kgotsa Nyaa

2.4.13. F a o re Ee, Tlhagisa mabaka

_____

_____

ANNEXURE F: ENGLISH QUESTIONNAIRE FOR THE TRADITIONAL HEALTH PRACTITIONERS (THPs)

Introduction

The questionnaire is aiming at investigating the nature of inter-professional collaboration between the Traditional Health Practitioners (THPs) and Community Nurses (CNs) in Primary Health Care (PHC). You are kindly requested to answer each question and reflect the true and genuine response. The researcher will fill in your responses and anonymity will be ensured.Thank you in advance for your cooperation.

SECTION: 1

1. Biographic data

1.1. Your gender?

Male		Female	

1.2.What is your age in complete years? _____

1.3. Which of the following best describes the area where you currently live?

Rural	Urban	Peri-urban

1.4. What is your marital status?

Married	Never married	Widowed	Divorcee

1.5. What is your level of education?

No schooling	
Below matric	
Matric or grade12	
Diploma or certificate	

1.6. What is your religious affiliation?

1.7. Which one of the following do you consult when you are sick?

Traditional Health Practitioners other than yourself	
Self-Managing	
Clinic	
Western doctors	

1.8. How many years have you been practising as a THP?_____

1.9. Which Traditional Health Practitioner's organization are you affiliated to?

_____

1.10. Are you affiliated to the new Interim Traditional Health Practitioners Council?

Yes or No

1.11. What type of Traditional Health Practitioner are you?

Traditional Doctor	
Traditional Surgeon	
Diviners *(Sankoma)*	
Traditional Birth Attendant	
Herbalist	

1.12. How many patients do you consult in a month? _____

1.13. What was duration of your training as a Traditional Health Practitioner? _____

1.14. To what extent are you willing to collaborate with the Community Nurses in providing healthcare services?

No willingness at all	To a lesser extent	To a moderate extent	To a greater extent

SECTION: 2

2. Collaboration elements

2.1. Mutual respect, mutual understanding and trust

2.1.1. Do you respect health care services provided to patients by the Community Nurses? Yes or No

2.1.2. Do you respect Community Nurses as healthcare practitioners in their own right? Yes or No

2.1.3. Do you regard yourself as superior or better than the Community Nurses? Yes or No

2.1.4. If yes explain:

_____

_____

_____

2.1.5. Do you recognize Community Nurses as important contributors to healthcare service delivery? Yes or No

2.1.6. Would you openly work with the Community Nurses? Yes or No

2.1.7. If no, state the reasons.

_____

_____

_____

2.1.8. Would you openly share your healthcare knowledge with the Community Nurses? Yes or No

2.1.9. Would you feel safe and secured when working with Community Nurses? Yes or No

2.1.10. If no, state reasons.

_____

_____

_____

2.1.11. Are you willing to work with Community Nurses in providing health care?

Yes or No

2.1.12. If yes, how would you prefer to work with Community Nurses?

_____

_____

_____

2.1.13. Do you participate in clinic forum (clinic committee)? Yes or No

2.1.14. Have you ever attended a meeting between the Community Nurses and Traditional Health Practitioners? Yes or No

2.2. Attitudes

2.2.1. Would you advice patients to consult Community Nurses for treatment?

Yes or No

2.2.2. Should patients consult (see) Traditional Health Practitioners or Community Nurses first? Tick the appropriate block.

Community Nurses first	
Traditional Health Practitioner first	
Anyone they prefer to consult first	

2.2.3 How would you react if you find that the patient has consulted Community Nurses before coming to you? Tick the appropriate block.

Angry	
Neutral	
Happy	

2.2.4. Would you consult Community Nurses when you are sick? Yes or No

2.2.5. If no, state the reasons.

_____

_____

_____

2.3. Referral systems

2.3.1. Would you accept patients referred to you by Community Nurses? Yes or No

2.3.2. Have you ever referred a patient to the Community Nurses for second opinion? Yes or No

2.3.3. If yes, state the health problem / condition that you referred the patient for?

_____

_____

_____

2.3.4 Have you ever consulted a patient referred to you by Community Nurses? Yes or No

2.3.5. If yes, what was the form of referral? Tick the appropriate block.

Verbal referral	
Written referral	
Accompanied / brought by the THPs	
Cannot remember	

2.3.6. Would you refer patients to Community Nurses without fear, guilt or insecurity? Yes or No

2.3.7. How often do you see/ consult patients that were seen by the Community Nurses?Tick the appropriate block.

Often (regularly / many times)	
Seldom	
Never consult / treat them	

2.3.8. Are you afraid to refer patients to Community Nurses? Yes or No

2.3.9. If yes, who are you afraid of?

_____

_____

_____

2.3.10. Would you provide feedback to the Community Nurses after consulting the patient? Yes or No

2.4.Support to collaboration

2.4.1. Have you ever attended a workshop or seminar with the Community Nurses? Yes or No

2.4.2. If yes, explain what was discussed.

_____

_____

_____

_____

2.4.3. Have you been informed about inter-professional collaboration between the Community Nurses and Traditional Health Practitioners? Yes or No

2.4.4. If no, who did you expect to inform you?

_____

2.4.5. Do you support the move to collaborate with Community Nurses? Yes or No

2.4.6. If yes, what kind of support do you recommend? State below.

_____

_____

_____

2.3.8. Are you afraid to refer patients to Community Nurses? Yes or No

2.3.9. If yes, who are you afraid of?

_____

_____

_____

2.3.10. Would you provide feedback to the Community Nurses after consulting the patient? Yes or No

2.4.Support to collaboration

2.4.1. Have you ever attended a workshop or seminar with the Community Nurses? Yes or No

2.4.2. If yes, explain what was discussed.

_____

_____

_____

_____

2.4.3. Have you been informed about inter-professional collaboration between the Community Nurses and Traditional Health Practitioners? Yes or No

2.4.4. If no, who did you expect to inform you?

_____

2.4.5. Do you support the move to collaborate with Community Nurses? Yes or No

2.4.6. If yes, what kind of support do you recommend? State below.

_____

_____

_____

2.4.7. Would you attend meetings that support collaboration between Traditional Health Practitioners and Community Nurses? Yes or No

2.4.8. Would you support government policies, initiatives and guidelines which support? Collaboration between Community Nurses and Traditional Health Practitioners? Yes or No

2.4.9. Would you encourage other Traditional Health Practitioners to collaborate with Community Nurses? Yes or No

2.4.10. Have you heard about the new Traditional Health Practitioners Act, Act 22 of 2007)? Yes or No

2.4.11. Do you know that there is a sub-directorate at the provincial Department of Health, that deals with traditional healers' forum in the North West Province? Yes or No

2.4.12. Do you think that it is important for the Traditional Health Practitioners to register with the following organizations; Traditional Health Organisation or Traditional Health Practitioners Council? Yes or No

2.4.13. If yes outline reasons

_____

_____

_____

_____

ANNEXURE G: RESULTS OF THE STUDY

Section 1

1. **Biographic data for**

Table 1.1: Which one of the following describes the area where you currently live?

Categories of healthcare professionals	Which one of the following describes the area where you currently live?						Total	
	Rural		Urban		Peri-Urban			
Community Nurses and Traditional Health Practitioners	(N)	%	(N)	%	(N)	%	(N)	%
	312	75.0	23	5.2	78	18.9	413	100.0

Table 1.2: Marital status

Categories of healthcare professionals	What is your Marital status?								Total	
	Married		Never Married		Widow		Divorcee			
Community Nurses and Traditional Health Practitioners	(N)	%	(N)	%	(N)%		(N)%		(N)	%
	210	50.5	140	33.7	40	9.0	26	5.9	416	100.00

Table 1. 3: What is your religious affiliation?

Religious affiliation	CNs and THPs	
Zion	(N) 14	% 3.8
African Methodist Episcopal	(N) 9	% 2.4
Others	(N) 280	% 75.1
Methodist	(N) 20	% 5.4
Anglican	(N) 18	% 4.1
Lutheren	(N) 21	% 5.6
Roman Catholic Church	(N) 10	% 2.7
African Catholic Church	(N) 1	% .3
Total	**373**	**100.0**

Table 1.4: Which one of the following do you consult when you are sick?

Categories of healthcare professionals	People to consult	Total	
Traditional Health Practitioners	Traditional Health Practitioner other than yourself	(N) 44	% 20.6
	Self Managing	(N) 61	% 28.5
	Clinic	(N) 96	% 44.9
	Western doctors	(N) 13	% 6.1
Total		**(N) 214**	**% 100.0**

Table 1 .5 : Which Traditional Health Practitioners' organization are you Affiliated to?

THPs Organization	(N)	%
Dingaka Association	(N) 81	% 37.9
Phuthi Miracle Healers	(N) 2	% .9
Traditional Health Organization	(N) 39	% 18.2
North West THPs	(N) 48	% 22.4
Others	(N) 24	% 11.2
None	(N) 19	% 8.9
Total	**(N) 213**	**% 100.0**

Table 1. 6 : Are you affiliated to the Interim Traditional Health Practitioners Council?

Categories of healthcare professionals	Are you affiliated to the Interim Traditional Health Practitioners Council?				Total	
	Yes		No			
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	0	0	214	100.00	214	100.0

Table 1.7: To what extent are you willing to collaborate with the Community Nurses?

Categories of healthcare professionals	To what extent are you willing to collaborate with the Community Nurses?								Total	
	Not willing		To a lesser extent		To a Moderate extent		To a greater extent			
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%
	2	.9	19	8.9	18	4.1	174	39.1	213	100.0

Section 2

2.1 Mutual respect, mutual understanding and trust

Table 2.1.1: Openly share healthcare knowledge with each other?

Categories of healthcare professionals	Openly share healthcare knowledge with each other				Total	
	Yes		No			
Community Nurses	(N) 138	% 71.5	(N) 55	% 28.5	(N) 193	% 100.0
Traditional Health Practitioners	(N) 158	% 73.8	(N) 56	% 26.2	(N) 214	% 100.0
Total	**(N) 296**	**% 72.7**	**(N) 111**	**% 27.3**	**(N) 407**	**% 100.0**

2.2 Referral system

Table 2.2.1: Referring patients to one another without fear guilt or insecurity

Categories of healthcare professionals	Referring patients to one another without fear, guilt or insecurity				Total	
	Yes		No			
Community Nurses	(N) 28	% 1 6.0	(N) 147	% 84.0	(N) 175	% 100.0
Traditional Health Practitioners	(N) 204	% 95.3	(N) 10	% 4.7	(N) 214	% 100.0
Total	**(N) 232**	**% 59.6**	**(N) 157**	**% 40.4**	**(N) 389**	**% 100.0**

Table 2.2.2: How often do you see or consult patients referred by THPs or CNs

Categories of healthcare professionals	How often do you see or consult patients referred by THPs or CNs?						Total	
	Often		Seldom		Never			
Community Nurses	(N) 38	% 19.4	(N) 114	% 58.2	(N) 44	% 22.4	(N) 196	% 100.0
Traditional Health Practitioners	(N) 79	% 36.9	(N) 87	% 40.7	(N) 48	% 22.4	(N) 214	% 100.0
Total	**(N) 117**	**% 28.5**	**(N) 201**	**% 49.0**	**(N) 92**	**% 22.4**	**(N) 410**	**% 100.0**

Table 2.2.3: Are you afraid to refer patients to THPs or CNs?

Categories of healthcare professionals	Are you afraid to refer patients to THPs or CNs?				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	112	60.5	73	39.5	185	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	3	1.4	211	98.6	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	115	**28.8**	**284**	**71.2**	**399**	**100.0**

Table 2.2.4: Reasons cited by healthcare professionals for being afraid to refer to one another.

s	CNs
ollaboration suggested by CNs	Afraid of THPs treatment no measurements
es shout at us	THPs are using concoctions and overdose
	Scope of Practice
	Do not know the scope of Practice for THPs and what treatment the patient will receive
	Health Authorities /government / law
	Accountability no conditions for referral
	Complications that may arise/ mismanagement
	Do not do further investigations and may have wrong diagnosis
	Drug toxicity, treatment reaction , they have no knowledge of what they treat
	Do not know where they are stationed
	Blame by patients if their medications do not work
	Afraid of the South African Nursing Council will sanction us
	It's the patients' choice to go to THPs
	Medications are not scientifically proven, mistrust
	My profession ; THPs are not professionally trained
	No sterility
	No policy from the Department of Health
	Outcomes and reaction of my superiors
	Patients ' relatives
	Fly by night THPs
	Religious background
	Worsen patient' conditions

Table 2.2.5: Giving feedback to one another after consulting a patient

Categories of healthcare professionals	Would you give feedback to one another after consulting a patient?				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	105	56.8	80	43.2	185	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	190	88.8	23	10.7	213	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	295	**73.9**	**103**	**25.8**	**398**	**100.0**

2.3.Support Collaboration

Table 2.3.1:Would encourage other THP or CNs to support collaboration?

ategories of healthcare rofessionals	Would you encourage other THP or CNs to support collaboration?				Total	
	Yes		No			
ommunity Nurses	(N)	%	(N)	%	(N)	%
	141	80.6	34	19.4	175	100.00
aditional Health actitioners	(N)	%	(N)	%	(N)	%
	208	97.2	6	2.8	214	100.0
otal	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	349	**89.7**	**40**	**10.3**	**389**	**100.0**

Table 2.3.2: What role do you prefer the THP to play in collaborating with CNs in Patient Care?

ategories of althcare ofessionals	What role do you prefer the THPs to play in collaborating with CNs in patient Care?								Total	
	Counsellor		DOTS supporter		Healer		No role			
mmunity Nurse	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%
	81	44.3	60	32.8	30	16.4	12	6.6	183	100.0

Table 2.3.3 : Have you heard about the Traditional Health Practitioners Act, Act 22 of 2007?

Categories of healthcare professionals	Have you heard about the Traditional Health Practitioners Act, Act 22 of 2007?				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	45	23.0	151	77.0	196	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	67	31.9	143	68.1	210	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	112	**27.6**	**294**	**72.4**	**406**	**100.0**

Table 2.3.4: Do you have the Traditional Health Practitioners Act, Act 22 of 2007 in your clinic?

Categories of healthcare professionals	Would you accept patients referred from each other				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	195	97.5	5	2.5	200	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	208	97.2	6	2.8	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	403	**97.3**	**11**	**2.7**	**414**	**100.0**

Table 2.3.5: Are you aware that there is a sub-directorate at the provincial Department of Health, that deals with traditional healers' forum in the North West Province?

Categories of healthcare professionals	Are you aware that there is a sub-directorate at the provincial Department of Health, that deals with traditional healers' forum in The North West Province?					
	Yes		No		Total	
Community Nurses	(N)	%	(N)	%	(N)	%
	126	70.8%	52	29.2%	178	100.0
Traditional Health Practitioners	(N)	%	(N)	%	(N)	%
	139	65.0	75	35.0	214	100.0
Total	**(N)**	**%**	**(N)**	**%**	**(N)**	**%**
	265	**67.6**	**127**	**32. 4**	**392**	**100.0**

Table 2.3.6: Would you visit THPs practice site (surgery/ home) to familiarize yourself with their health practice?

Categories of healthcare professionals	Would you visit THPs practice site (surgery/ home) to familiarize yourself with their healthcare practices?				Total	
	Yes		No			
Community Nurses	(N)	%	(N)	%	(N)	%
	107	58.5	76	41.5	183	100.0

ANNEXURE H: APPROVAL FROM THE NORTH WEST UNIVERSITY MAFIKENG CAMPUS ETHICS COMMITEE.

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
INSTITUTIONAL OFFICE

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title :

Investigation of inter-professional collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the North West Province (NWP).

Student/Projectleader: Prof.U Useh

Ethics number: NWU-00034-11-A9

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Expiry date: 2016/05/30

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project.

Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal ethics approval certificate will follow shortly.

Yours sincerely

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
INSTITUTIONAL OFFICE

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee:

Project title :

Investigation of inter-professional collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the North West Province (NWP).

Student/Projectleader: **Prof.U Useh**

Ethics number: NWU-00034-11-A9

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

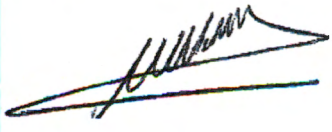
Expiry date: 2016/05/30

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project.

Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal ethics approval certificate will follow shortly.

Yours sincerely



ANNEXURE I: APPROVAL FROM THE NORTH WEST DEPARTMENT OF HEALTH: POLICY, PLANNING AND RESEACH, MONITORING AND EVALUATION.

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2nd Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Tel: (018) 387 5757
kshopwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Mrs M.G Montshioa
North West University

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Investigation of Inter-Professional Collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the Ngaka Modiri Molema District in the North West Province.

The Subject matter above bears reference

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

25/08/2011
Date

Healthy Living for All

DEPARTMENT OF HEALTH
PRIVATE BAG x2068
2011 -08- 25
SUPERINTENDENT GENERAL

ANNEXURE J: PERMISSION TO CONDUCT RESEACH FROM N.M.M DISTRICT.

TO: THE CHIEF DIRECTOR: MR G. HENNING
NGAKA MOLEMA DISTRICT
DEPARTMENT OF HEALTH
NORTH WEST PROVINCE

SUBJECT: PERMISSION TO CONDUCT A RESEARCH PROJECT

Sir

I am a Masters student at the North West University (Mafikeng campus) and currently employed by the Department of Health, training Primary Health Care (PHC) Nurses for the Ngaka Modiri Molema (NMM) district.

The research title is: "Investigation of inter-professional collaboration between the Traditional Health Practitioners (THPs) and the Community Nurses (CNs) in Primary Health Care (PHC) provision in the NMM district of the North West Province" (NWP).

The purpose of the study is to investigate and describe the nature and extent of inter-professional collaboration between the THPs and the CNs in the PHC delivery in the NWP.

The specific objectives of the study are to investigate the:

1. Specific elements of collaboration such as mutual respect, mutual understanding and trust, in inter-professional collaboration,
2. Attitudes of both THPs and the CNs,
3. To describe the referral systems between THPs and the CNs, and
4. To identify factors that support inter-professional collaboration between the THPs and the CNs in PHC.

A quantitative approach for data collection will be used as follows:
A self constructed interview schedule shall be used to collect data from the THPs through face to face interviews. The questionnaire shall be developed in English and translated to Setswana for the THPs. English questionnaire will be used to collect data from CNs at their respective clinics.

I intend to conduct the research project in the five (5) sub-districts of the NMM district I therefore request permission, to conduct the above-mentioned research project.I undertake to strictly adhere to the ethical principles of nursing research I.e. autonomy, justice, non- maleficence and beneficence.

Enclosed find the following:
- Approval letter from the North West Department of Health
- Approval letter from relevant committees at North West University (Mafikeng Campus).

My supervisors are: -Professor Efe Useh : 018 – 389 2531
-Dr E Manyedi : 018 - 3892111

My contact details are herewith attached for further clarity:

0823554036 / 0716884244
018 - 3841123
E –mail address is Mamotale@nwpg.gov.za .

Thanking ycu in advance

Regards

MAMOTALE MONTSHIOA
Mcur student

Approved
31/05/2011.
J.G. HENNING
CHIEF DIRECTOR
NGAKA MODIRI MOLEMA DISTRICT

ANNEXURE K: REQUEST FOR APPROVAL FROM VAN SCHAIK PUBLISHERS.

27.07.2012

To : Ms L Lamb
Van Schaik Publishers
Pretoria

From : Mrs M .G Montshioa
Student number: 22080805
North West University (Mafikeng Campus)

Subject: Request for approval to use an excerpt for a dissertation

Dear Sir / Madam

I am a masters student at the North West University (Mafikeng Campus) and the title of my research is: Investigation of inter-professional collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the Ngaka Modiri Molema district in the North West Province (NWP). I therefore request approval to use an excerpt figure 11.6 : Corresponding aspects of the traditional medical and biomedical model sourced from Spring(1980 :50) as depicted from your book entitled: Health and Health Care in South Africa (Van Rensburg, H C J , 2009 : 546).

It will be appreciated if a written approval can be granted.

Regards

Mrs M. G Montshioa

ANNEXURE L: REQUEST FOR APPROVAL FROM PRENTICE HALL PUBLISHERS.

27.07.2012

To : Prentice Hall Publishers
USA

From : Mrs M .G Montshioa
Student number: 22080805
North West University (Mafikeng Campus)
Republic of South Africa (North West Province)

Subject : Request for approval to use an excerpt for a dissertation

Dear Sir / Madam

I am a masters student at the North West University (Mafikeng Campus) and the title of my research is: Investigation of inter-professional collaboration between Traditional Health Practitioners and Community Nurses at Primary Health Care in the Ngaka Modiri Molema district in the North West Province (NWP). I therefore request approval to use an excerpt figure 21-.1 Leininger's Sunrise Model to depict theory of culture care diversity and culture care universality as sourced from Leininger (1991 :43) as depicted from your book entitled: NURSING THEORIES: THE BASE FOR PROFESSIONAL NURSING PRACTICE (George, B J , 2002 : 496).

It will be appreciated if a written approval can be granted.

Regards

Mrs M. G Montshioa
Mcur student

ANNEXURE M: PROOF OF LANGUAGE EDITING.

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29th October 2012

This serves to confirm that I have read and edited Mrs Mamotale Gladys Montshioa's Master in Community Nursing Science dissertation titled:
"Investigation of inter-professional collaboration between traditional health practitioners and community nurses at primary health care in the Ngaka Modiri Molema District in the North West Province (NWP)".

The candidate corrected all language errors identified.

The document presentation is of an acceptable academic and linguistic standard.

Thank you,

Prof. D.A. Isabirye
Chemistry Department